# Buckinghamshire Healthcare NHS Trust

## Quality Report

Amersham Hospital
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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 | Requires improvement |
|---|---|
| Are services at this trust safe? | **Requires improvement** |
| Are services at this trust effective? | **Requires improvement** |
| Are services at this trust caring? | **Good** |
| Are services at this trust responsive? | **Requires improvement** |
| Are services at this trust well-led? | **Requires improvement** |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We had previously carried out a comprehensive inspection in March 2014 because Buckinghamshire Healthcare NHS Trust was in special measures and had been flagged as a potential risk on the Care Quality Commission's (CQC) intelligent monitoring system. In March 2014, we inspected Stoke Mandeville Hospital, Wycombe Hospital and Amersham Hospital. We did not inspect the Minor illness and Injury Unit at Wycombe Hospital as this is run by Buckinghamshire Urgent Care Service. The trust came out of special measures in 2014. However, there were still concerns about staffing levels (particularly of senior medical staff at night and weekends), the emergency care pathway and patients' experiences of care . The responsiveness of emergency care services and the effectiveness of end of life care services were rated 'inadequate' at this time. These reports are available on our website.

For this inspection, we carried out a comprehensive inspection of the trusts community health services in Buckinghamshire on 24 – 27 March 2015 and unannounced inspections on the 10 - 11 April 2015. We also undertook an unannounced focused inspection of urgent and emergency care and end of life care services at Stoke Mandeville Hospital and end of life care services at Wycombe Hospital on 24 - 27 March 2015. This is because these core services had at least one inadequate rating based on the previous inspection findings in March 2014.

Overall, this trust was rated as 'require improvement'. The trust required improvement to provide safe, effective, responsive, and well led services, we rated it 'good' in terms of providing caring services.

Our Key findings relate to the inspections findings in March 2015.

**Key findings from our focused inspections**

- During our inspection in March 2015 we identified that the trust had made significant improvements to the urgent and emergency care services. The pace of change over the last 12 months was rapid and there was clinically led service developments. Services were being planned based on the needs of the local population and action was being taken, in conjunction with health and social care partners across Buckinghamshire, to respond to demands. There were new services to speed the assessment and treatment of patients and avoid patient admission to hospital. The trust had identified peak attendance times in the emergency department (ED) and planned staffing to respond. The new services included an initial assessment and treatment centre in the ED, assessment and observation centre (AOU), short stay acute medical unit, and ambulatory care service. These areas still needed to function appropriately across the hospital as patients were still delayed in the ED.
- Patients in the ED were assessed and treated within standard times and the modified early warning score was used effectively to identify deterioration in a patient's clinical condition. The service needed to improve its assessment and documentation of patient risks, for example, for falls and pressure ulcer damage. The service had improved its performance against the national emergency access target (that is for 95% of patients to be admitted, transferred or discharge within four hours). However, the target was not being met consistently. The hospital response to the flow of patients still needed to improve. We observed the ED to be busy but calm. Many patients were still waiting for excessively long periods in the ED although they did not have long waiting times on trolleys or in corridors.
- We found improvements in end of life care. Nursing and medical care had improved and patients received better symptom control and anticipatory drugs for pain relief. Patient's nutrition and hydration needs were being assessed. Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment.

**Key findings from our community health services inspection**

- Community services varied in their service developments. The trust clinical strategy was around the integration of acute, community and primary care service. This was developing in adult community

# Summary of findings

services and under strategic development and consultation in end of life care and community inpatient services. The strategy was undeveloped in children, young people and families services. Governance arrangements and risks needed to be better managed across all community services. The leadership of the children, young people and families services was 'inadequate' with some managers at team and operational level demonstrating inappropriate behaviours to manage risks and ensure and open and transparent culture. Patients were complimentary about services although some concerns were indicated in community hospitals

**Children, young people and families**

- The majority of parents told us they were treated with dignity and respect by community staff. The staff displayed an encouraging, sensitive and supportive attitude and children and young people's personal, social and cultural needs were recognised. Staff understood and respected confidentiality.
- Patients, and those close to them, were involved in their care and treatment. The staff took the time to tell children in an age appropriate manner what was going to happen and encouraged them to ask any questions about the treatment. Parents were supported to manage their own health, care and wellbeing. Parents told us they felt confident in managing their children's needs. Parents and children were supported emotionally.
- The parents we spoke with told us that the services were accessible and that staff were knowledgeable, informative and caring.
- The trust's incident report system was not being used appropriately. Some staff were not reporting incidents and some had been discouraged to report. Where incidents were reported, there was evidence of action but there was not consistent learning or improvement for when things went wrong. There was no assurance that all incidents and risks were being adequately identified and managed.
- Staff we spoke with were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes. However, some staff within school nursing teams told us that they had been asked to participate in child protection work beyond their competencies. Information was unclear on the level of safeguarding children training staff had undertaken.
- Staff identified that budgetary constraints meant that some equipment was not available, such as clinical needles for immunisation and toys to distract children when receiving treatment.
- The trust used a mixture of electronic and paper records. Some electronic systems were not compatible and so information was not being shared effectively across services about children's care. Records did not appropriately include salient information that summarised children's health needs and family history.
- Staff were following infection control procedures but toys were not being appropriately cleaned. Trust targets for staff mandatory training were not met.
- The service was assessing risks to patients but were not responding effectively due to workload pressures. Some children with identified risks were not being seen in a timely manner or could be missed because processes were not robust.
- Staffing levels were assessed and vacancies were identified as low. However, a matrix for weighting health visiting caseloads had identified a shortfall in health visitor hours. The ratio of qualified school nurses to number of secondary schools was below that recommended by national guidance. Staff within health visiting and school nursing teams told us that they were unable to perform certain aspects of their role due to workload pressures. The family nurse partnership could only fulfil 40% of its programme because of staffing capacity
- Medicines were appropriately managed.
- National and evidence based practice guidelines were used to define services. However, the guidance was not always followed for example, there were only targeted, not universal antenatal contacts by health visitors; this meant there was limited early identification of need and risk. The trust was not meeting its own performance targets in key areas and there was not effective audit and monitoring to demonstrate patient outcomes or compliance with quality standards.
- There were a limited number policies that covered care and treatment to children and young people and

practice was inconsistent. Staff did not have support to develop professional practice around national guidance and there was inconsistent care and support provided across teams.

- Staff supervision and appraisal varied and staff identify difficulties in accessing training. There were no specialist trained nurses working with children with a learning disability. Staff working with children with a learning disability told us they did not fully understand the Mental Capacity Act 2005 and the deprivation of liberty safeguards (DoLS) to ensure decisions were being taken in a child's best interest.
- There was effective multi-disciplinary working in therapy teams but coordination of care pathways and IT arrangements to share information or liaise with other agencies, such as GP surgeries, midwives and across acute hospital care, were inconsistent . There were good arrangements for multi-disciplinary team working for looked after children.
- Community children and young people's services were commissioned with indicators to monitor operational service delivery. The services were not informed by the needs of the population and not addressing the needs of different people.
- The initial assessment within 28 days for looked after children target were not met. The waiting list for the learning disability service was not meeting the 18 week waiting time target.
- Staff had had training in equality and diversity and individually took account of patient needs but services were not offered to support the needs and preferences of different people that might be based on age, gender, race or religion. There was no evidence of reasonable adjustments for people with a physical disability. Interpreter services were available but information leaflets were only printed in English.
- There was not a consistent way of logging, investigating, responding to and learning from complaints. Most staff did now the process for handling complaints. People we spoke with did not know how to make a complaint or raise concerns. Where concerns had been raised, these were not always addressed.
- Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. We saw evidence of person-centred care that showed community staff were responsive to individual needs and worked flexibly with people towards improved health and wellbeing.
- Children had good access to services, and parents could attend appointments with health visitors and at child health clinics at convenient time

- The trust did not have a strategy for children and young people's services. Staff did not know and understand what the vision, values and strategy were for the trust. The majority of staff told us that the services they delivered were not high on the trust agenda.
- Staff within school nursing team told us that they were discouraged or not heard when they raised concerns about being able to deliver services safely. There had been a lack of management support and staff were dissuaded and bullied if they raised concerns. The concerns included being told to take on responsibilities beyond their competencies and workload pressures leading to staff being unable to perform some of their role. A new database tool had identified risks in children but staff were unable to address these. Staff reported their concerns but these had not been acted on and these had not been escalated to the board .
- The was a process of governance and performance was monitored but many staff told us the culture was focused was on achieving performance indicators and their skills and many aspects of the preventative work were not valued.
- Some policies and pathways in community children and young people's services had been developed within teams of staff at a local level. They had not gone through a governance process and had not been ratified by the trust.
- Risks were not being identified, monitored and assessed appropriately. This was being impeded by individuals rather than processes. There were not robust lone working arrangements or an escalation process. The trust board had only recently started to engage with the service to understand what services were delivered and identify areas of concern.
- The service supported innovative practice but staff were not well resourced or given time to contribute or deliver this effectively. The service did not have plans for future improvement or sustainability, in terms of

staffing, succession planning and managing finances. Most staff told us the focus of the trust was on the acute sector and that children and young people were not high on the trust agenda.

- Patient feedback was developed in therapy services and in the Family Nurse Partnership team but there were limited opportunities for people who used the service to give feedback elsewhere. .
- The Family Nurse Partnership (FNP) service had the right structures and processes and assessed as performing well.

**Adult community services**

- We found staff were caring and compassionate. Without exception, patients we spoke with praised staff for their empathy, kindness and caring. Some patients described what they felt were examples of staff going above and beyond the requirements of their job in order to ensure their wellbeing. There were programmes aimed at meeting the needs of specific communities, for example, a drop-in programme run by the diabetes team for patients over Ramadan to help them make adjustments to their medication while fasting.
- Incidents and near misses were not always reported. There was a lack of clarity about who would report an incident which occurred during a home visit or in a community based clinic. Many staff were not aware of the requirements of the Duty of Candour in handling incidents.
- There were significant staffing shortages in many of the community services we visited, with particular shortages of nurses, physiotherapists and occupational therapists. Staff told us that as a result of staff shortages there were waiting lists for some services and that other services were scaled back. There were many examples of this. Staff told us there was a 14–16 week wait for patients to access services at the Thame Day Hospital because there were insufficient staff to provide the service. The pulmonary rehabilitation clinic we visited was short of a physiotherapist and staff told us this had contributed to a delay in providing one of the service’s scheduled rehabilitation programmes. Staff at the Drake Day Hospital told us they prioritised the most complex patients, for example those patients requiring neuro-rehabilitation, and that other patients could not be treated because there were not enough occupational therapists.
- Facilities we visited were clean and hygienic. Trust premises and community locations were generally well maintained although facilities for the head injury service in Cambourne required review. Equipment was available for patients in their homes and was usually delivered promptly, although there were some problems in delivering non-urgent equipment, which were being discussed with the equipment provider. Electronic patient record keeping systems were not often linked together, which meant that some services could not access information about patients which was held by other services.
- Staff across all services described anticipated risks and how these were dealt with. Lone working policies were in place but community staff did not feel these addressed their specific working conditions. Safeguarding protocols were in place and staff were familiar with these. Staff were able to describe the types of major incidents in which they could potentially be involved and the system for responding to major incidents.
- Community services took into account guidance from the National Institute for Health and Care Excellence (NICE). There was well established multidisciplinary team working across almost all the community services we visited, although further work was required to clarify referral criteria between services. Staff had statutory and mandatory training, and described good access to professional development opportunities. However, training in and understanding of the Mental Capacity Act 2005 was variable.
- Patient outcomes were monitored but were aggregated with divisional level data which included data from acute and community services. There were limited systems in place to monitor the performance of community services specifically. Data provided by the trust covering the period January 2014 to January 2015 suggested improving outcomes for patients. Incidents of pressure ulcers varied throughout the period and a plan was in progress to address this.

- Patient feedback was collected and used in planning many of the services we visited, most frequently through surveys or focus groups. Feedback from patient surveys shown to us by trust staff was, almost without exception, positive. Lessons from incidents and complaints were usually shared within the services in which they occurred, but lessons learned from other services within the trust were not routinely communicated.
- Most staff we spoke with felt they could discuss concerns with their line manager but many felt the trust's senior management could do more to involve them in discussions which affected community services. Community staff felt that trust-wide governance and leadership arrangements lacked sufficient consideration and understanding of community services. Staff identified the availability of community services and referral criteria as being key areas for improvement, as well as training, and policies and procedures that needed to better reflect the context in which community staff worked.
- Performance indicators were used by management to monitor the quality of community services, but performance outcome data for community services only were limited. For example, the community services quality dashboard combined data from all seven community localities and it was not possible to review results by individual adult community healthcare team. Where outcome data was available for community services, they were usually aggregated with patient outcome data from the trust's acute services.
- Elements of the trust's vision and strategic forward plan had been or were being implemented in relation to adult community services. Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy. Trust management recognised concerns about the sustainability of current staffing levels and described initiatives to address this.
- There was a clearly embedded ethos of improvement and innovation in some services. This was particularly the case in cardiac rehabilitation and respiratory services, the chronic fatigue and pain management services, and the community diabetes service.

**Community inpatient services**

- 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, 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 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.

# Summary of findings

- 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. 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.

**Community end of life care services**

- Staff demonstrated a caring and compassionate approach. Patients and their families were positive about the care and support they received and the way they were treated. Staff were courteous and treated patients and their families with dignity and respect. Patients and their families were involved and encouraged to be partners in their care and in making decisions.
- People and staff work together to plan care and there is shared decision-making about care The CNSs provided emotional support and would refer patients to other professionals if additional support was required. The trust had developed an action plan to improve its end of life service and a project lead had been employed to move this forward. The trust had engaged with staff, patients and their relatives as part of this project.
- The CNSs took a holistic approach to their role and the service was available to all. The children's hospice at-home team offered individually tailored care, adapted to the child and family's needs.
- Incidents were reported and there was evidence of learning and improvement as a result. Safeguarding procedures were understood.
- Patients were supported to understand the medication they were taking and how this could be best used to control their symptoms. Medicines to support patients at the end of life were available in the community. Patients had the equipment they required to support their care safely in their own home.
- Staff followed good infection control procedures.
- There were sufficient specialist staff to support patient.
- Staff used records appropriately and were well informed about the potential risks for patients and how these were to be managed. Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were being used and this was monitored through audit.
- In line with national recommendation the Liverpool Care Pathway was no longer being used and the trust had developed a new pathway that was about to be trialled. Consideration was being given to the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People.
- New treatment escalation plans had also been developed in line with national guidance. Patient's pain was well managed and the clinical nurse specialist (CNSs) worked in partnership with patients to ensure that this was achieved. Patients nutrition needs were discussed and reviewed by the CNS as part of their holistic approach.
- The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators. Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.
- Training in end of life care was available to all staff and specialist staff was further supported to develop their skills. A
- There was a single point of access for all referrals for specialist palliative care and anyone, including parents, could refer a child to the children's palliative care team. Staff worked together to provide a multidisciplinary service and GP services to provide holistic care and prevent emergency admissions.

# Summary of findings

- Staff had the information they required to care for patients and were conscious and informed about the requirement to seek consent.
- An interpreting service was available although family members often acted as interpreter.
- The CNS managed their own diaries to ensure that patients were visited at time suitable for them. The children's palliative care team worked in a similar way liaising with families and scheduling support at a time that would best meet their needs.
- Support and advice was available 24 hours a day and staff were clear on how to access this support. The community teams worked together to support patients and their families and to ensure that they had the support and equipment they required.
- There was a clear vision for the service and the end of life care strategy was being reviewed to ensure that it reflected the service as a whole. The trust was actively making changes to the service to ensure it better reflected current guidance, although while there was some monitoring of the quality of the service, this required further development to include audit and the monitoring of outcomes for patients.
- The director of nursing was the lead for the service at board level and had clear insight into the challenges they were facing and the changes being made. At a local level there was respect for the lead consultant in palliative care. The matron's role had been expanded and their responsibilities increased, and they were receiving support with their development to assist them in their role.
- There was an open culture that placed the patient and their family at the centre. There was a team approach to caring for patients in the community, with joint working between specialist staff, the adult community healthcare team and the community hospitals.

We saw several areas of outstanding practice including:

- Community adult health services were available to patients 24 hours a day, seven days a week. This included nurses caring for patients in their homes at night.
- In the integrated cardiac rehabilitation service, new technology was used to improve pathway tracking of patients and provide outcome data. Staff told us the information generated as a result of this project helped them to improve the services they offered to patients. The new systems and technology, they said, had improved uptake of treatment from 52% to 82%.
- The trust provided a community diabetic service which offered two hour clinics twice a week for non-English speaking patients, and provided interpreters. Clinics could be accessed by appointment or drop in. There was also a three week education session provided over Ramadan for healthcare professionals and a drop-in programme for patients who had diabetes to help patients make adjustments to their medication while fasting.
- Staff from the respiratory team told us there was a single point of access seven days a week for specialist nursing services provided by their team. Patients, GPs, community nurses and staff from the hospital's inpatient wards could ring the team on a dedicated phone number for advice and support.
- Patients were given an individualised, multidisciplinary risk assessment regardless of the service they used. For example, patients had assessments as required for mobility, nutrition, pressure ulcers, mental and emotional wellness, occupational therapy, and home environment. We saw evidence of this in almost all the patient records we looked at.
- The trust contributed to the development, launch and use the Bucks Coordinated Care Record. This is a county-wide electronic end of life register that GP practises, NHS Trusts and hospices have signed up to use to coordinate care and services.
- The specialist palliative care nurses provided a daytime service with telephone advice and support out of hours. Face to face support was available out of hours from the district nurse team. The children's team worked flexibly and provided a 24 hour service when a child was approaching the end of their life.
- 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.

# Summary of findings

- The school nurses were the first in the country to use a new online resource tool. This gave local schools access to an online portal to identify their top three health priorities so school nurses could tailor support, providing early intervention and prevention

However, there were also areas of practice where the trust needs to make improvements.

Importantly, the trust must ensure:

- Patient risk assessments and the documentation that supports them are routinely completed in the Emergency Department.
- There is effective clinical engagement for a hospital wide focus to patient flow and escalation processes and this is monitored.
- There are timely GP discharge summaries following a patient admission to the Emergency Department.
- There is a timely replacement for the Liverpool Care Pathway and all staff follow the current interim policies.
- Staff complete the end of life care plans (Hearts and Minds – end of natural life) appropriately to NICE guidelines for holistic care and they are followed.
- All staff consistently and appropriately complete the DNACPR forms and discussions between patients and relatives are recorded in patient records.
- The overhead lighting lamps in the hospice are replaced to reduce the risk to patients of contact with hot surfaces.
- Staffing levels in the mortuary are reviewed give staff adequate rest time between shifts and to reduce the levels of lone working.
- Mortuary staff have appropriate equipment for bariatric (obese)patients to reduce the risk of harm to staff from inappropriate manual handling.
- Deceased patients are clearly and appropriately identified when being transferred from wards to the mortuary.
- All staff involved in end of life care can identify a patient at the end of life (12 months) to ensure that referrals to the specialist palliative care team are made in a timely manner.

Community adult services

- There are effective operation of systems designed to enable it to identify, assess and manage risks relating to patients which arise from incidents and near misses.
- There are sufficient numbers of suitably qualified staff in all community teams and ensure safe caseload levels.
- The suitability of premises and facilities for the head injuries unit in Cambourne.
- There are suitable arrangements for the privacy and dignity of patients using the multidisciplinary day assessment service (MuDAS).
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from inaccurate patient records or records which cannot be located promptly when required.
- Staff receive appropriate training on the Duty of Candour and the Mental Capacity Act 2005.
- Community staff and managers have clinical supervision and support to undertake their role.

Community children and young people services

- Staff are able to freely raise any concerns about being unable to deliver services safely and that this is heard and acted on by management.
- Staff use the incident reporting system to report concerns
- Staff have appropriate safeguarding and mandatory training
- Ensure there are mechanisms in place to obtain feedback from people who use services.
- Staffing levels are assessed and reviewed using an evidenced based tool and meet recommended guidelines.
- Staff can appropriate identify and respond to patient risks
- All pregnant women receive a universal antenatal contact with a health visitor.
- Multi-disciplinary team working is effective and pathways of care are coordinated and, where necessary, children receive early support.
- There is an audit programme to monitor the quality and safety of services.
- Children on the learning disability waiting list are appropriately managed
- Consistently log, investigate, respond and learn from complaints in the community children and young people's services.
- Staff fully understand the Mental Capacity Act 2005 and the deprivation of liberty safeguards.
- There is a service strategy and services are planned effectively around prevention and local need.

# Summary of findings

- The leadership concerns are fully investigated and action is taken to ensure and open, transparent and supportive culture exists in the service.
- Governance arrangements are improved.
- Patient engagement and feedback is improved across the service
- Staff engagement is improved across the service.
- Budgetary constraints do not adversely affect the care and treatment of children, young people, and parents and carers.

Community inpatient services

- 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 to use the information to improve the service provided.
- 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 accident 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

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Buckinghamshire Healthcare NHS Trust

Buckinghamshire Healthcare NHS Trust is a major provider of community and hospital services in South Central England, providing care to a population of more than 500,000 for people in Aylesbury Vale, Wycombe, Chiltern and South Buckinghamshire. The trust had approximately 6,000 staff and 822 beds in total. There were two acute hospital sites at Stoke Mandeville Hospital and Wycombe Hospital, and also community hospital sites at Buckingham Community Hospital, Chalfonts and Gerrards Cross Hospital, Marlow Community Hospital, Thame Community Hospital and Amersham Hospital.

Buckinghamshire Healthcare NHS Trust was formed in a merger of the acute and community hospitals in 2010. The trust had faced some financial challenges and had developed services across Buckinghamshire where most emergency and inpatient services were centralised at Stoke Mandeville Hospital. In 2013, the trust was identified nationally as having high mortality rates and was one of 11 trusts placed into special measures following a review by Sir Bruce Keogh (the Medical Director for NHS England) in July 2013. We inspected the trusts acute services in March 2014 and the trust came out of special measures in 2014. There were still concerns about staffing levels (particularly of senior medical staff at night and weekends), the emergency care pathway and patients' experiences of care . The responsiveness of emergency care services and the effectiveness of end of life care services were rated 'inadequate' at this time.

We undertook this comprehensive inspection on 24 – 27 March 2015 and 10 - 11 April 2015. We inspected community health services in Buckinghamshire and also undertook an unannounced focused inspection of urgent and emergency care and end of life care services at Stoke Mandeville Hospital and end of life care services at Wycombe Hospital.

The inspection team inspected the following core services :

Acute services

- Urgent and Emergency Care
- End of life care

Community services

- Children, young people and families
- Community health services for adults
- Community inpatient services
- Community end of life care services.

## Our inspection team

Our inspection team in March 2015 was led by:

**Chair:** Mike Lambert Consultant in Emergency Medicine Norfolk and Norwich University Hospital

**Team Leader:** Joyce Frederick, Head of Hospital Inspections, Care Quality Commission

The team of 35 included CQC inspection managers and inspectors. They were supported by specialist advisors, including health visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a paediatrician, a geriatrician, 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.

# Summary of findings

## 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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the local Healthwatch.

We carried out an announced inspection visit on 24 –27 March 2015. We carried out unannounced inspection on 10 and 11 April 2015. We held focus groups and drop-in sessions 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 in ward areas, community clinics and in their homes. 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 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 Buckinghamshire Healthcare NHS Trust.

## What people who use the trust's services say

In March 2015, people in community services told us

- Patients and carers receiving adult community services told us they were pleased with the services they received and praised the professionalism of trust staff.
- People were positive about the community end of life care support they received. There were good relationships built on trust. People complimented the staff on their caring approach and were clear that information was provided in a way they could understand.
- The majority of parents told us they were treated with dignity and respect by community staff. They told us they felt confident in managing their children's needs. We heard comments such as, "The health visitors are really helpful and there when I need them.", and the "doctor … is brilliant all the team are available, helpful, cannot fault". Many parents commented on the service being accessible and the staff being approachable. Parents and carers told us that staff always involved them in decisions about care and treatment for their children. One parent told us that a member of staff "is always there, a lifeline…..she helps me feel in control of all the changes every day
- Most patients in the community hospitals told us they were looked after and treated with dignity and respect. However, there were some concerns about staff attitude at Buckinghamshire Community Hospital.

## Facts and data about this trust

**Buckinghamshire NHS Trust: Key facts and figures**

**Context.**

- Around 728 beds
- Population around 505,000
- Staff: 6,000 (1,000 community staff)

# Summary of findings

**1. Activity**

- Inpatient admissions 91,307pa
- Outpatient attendances 473,949pa
- A&E attendances 108, 615 (2014/15)
- Births 5,684pa
- Community patients 517,000
- School children supported 18,000

**2. Beds and Bed occupancy**

- General and acute 675 (B.O. 92.3%)
- Maternity 56 (B.O. 60.9%)Adult critical care 17 (B.O. 86.5%)
- PICU n/a
- NICU 3 (B.O. 100%)
- Community beds 108

**3. Intelligent Monitoring** – priority banding - Recently inspected (March 2015)

- Elevated Risk Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14)
- Risk: A&E Survey Q22: If you were feeling distressed while you were in the A&E Department, did a member of staff help to reassure you? (01-Jan-14 to 31-Mar-14)
- Risk: TDA - Escalation score (01-Jun-14 to 30-Jun-14)
- Risk: NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff (01-Sep-13 to 31-Dec-13)

**4. Safety**

- 3 never events (2012/14).
- STEIS 127 SUIs (Dec 2012-Jan 2014)
- NRLS Deaths 10 Severe 31 Moderate 833
- Safety thermometer
  - Pressure ulcers - High but variable
  - VTE - High
  - Catheter UTIs - High
  - Falls - Low but variable
- Infections
  - C. diff 34
  - MRSA - 4 (August 2013 – July 2014)

**5. Effective**

All within expectations

- National Care of the Dying Audit - Hospitals (2013/14) - 5 out of 7 organisational indicators not achieved; clinical indicators lower, but similar to the England average.

**6. Caring**

- CQC inpatient survey - within expectations
- FFT Inpatient : similar to other trusts (above England average overall, March 201%) A+E: similar to other trusts (above England average ) (March 2015)
- Maternity survey 2013: within expectations
- Cancer patient experience survey
  - Performed better than average for 5 out of 69 questions and worse than average for 8 out of 69.

**7. Responsive**

- A&E 4 hr standard – Inconsistent. January to March 2015 91%.
- A+E left without being seen: similar to England average.
- Cancelled operations: average
- Delayed discharges: average

**8. Well led**

- Sickness rate 4.2% (England average = 4.2%)
- Agency 3.7% (average to area)
- FTE nurses/bed day 2.06 (above average)
- Staff survey 2014 – overall staff engagement worse 20% of trusts.
- GMC survey :

The trust's performance was found to be worse than expected in two or more areas for the following specialties:

- General (internal) Medicine
- Geriatric Medicine
- Trauma and Orthopaedic Surgery

The trust's performance was found to be worse than expected in three or more specialties for the following areas:

- Overall satisfaction
- Clinical supervision
- Adequate experience

# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|
| **Are services at this trust safe?** | Requires improvement |

Overall we rated safe in the trust as 'requires improvement'. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital, Amersham Hospital and the provider report for Buckinghamshire Healthcare NHS Trust (2014). Please also refer to the community health services report for children, young people and families, adults, inpatient services and end of life care.

Acute services

Infection control was appropriately managed and incident reporting had improved. Staff were responding appropriately to patient risks and overall appropriate equipment was available. Staffing had improved in the emergency department so that there were reduced numbers of agency staff and senior nursing that monitored standards of care. Senior medical staff presence had improved at the weekend for emergency patients but there was inadequate junior doctor cover for numbers of medical patients on inpatient wards out of hours and at the weekend.

Community health services

There were safety procedures in place but these were not being used effectively. In some areas we had concerns that patient safety risks were not appropriately identified or escalated. Community end of life care services were rated as 'good'

**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 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
- The trust had reported compliance with this regulation to the trust board and there was an action plan in place to ensure the requirements of the regulation was being met.
- Overall we found that staff were familiar with the principles of being open and transparent and were aware of the need to report when things went wrong. However, not all were familiar with the Duty of Candour or that this duty placed a legal requirement to report and act on such incidents.

# Summary of findings

- Staff had not had formal training on the Duty of Candour and not been given information or guidance to follow.

**Safeguarding**

- The trust had received the “Investigation into the Association of Jimmy Saville with Stoke Mandeville Hospital” A Report for Buckinghamshire Healthcare NHS Trust, in February 2015. The report had concluded “The current Buckinghamshire Healthcare NHS Trust has undergone a stringent process of review and investigation over the past two years in relation to safeguarding and governance. The Trust has worked with independent external agencies and this Investigation to ensure that its processes are fit for purpose and provides a safe environment for patients, staff and visitors”. The report made several recommendation made for the trust and the wider NHS. These including: to ensure all staff, volunteers and frequent including high profile visitors had appropriate checks (for example, disclosure and barring checks); ensure effective staff training and reporting of incidents, provide accurate data on safeguarding, particularly from A&E departments and support people who are identified as victims of abuse. The trust was implementing these actions.
- 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 disability 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.
- Some locality teams had local safeguarding leads who they could access for support and who provided training in safeguarding, although not all staff we spoke with were aware of this.
- Overall, staff said they felt confident in raising safeguarding concerns and were supported to do so by their managers. Staff we spoke with were able to give examples of safeguarding incidents they had been involved in and how these were escalated. They knew who to contact in order to report a safeguarding concern.

- Staff training on adult and children's safeguarding varied and overall trust targets were not being met. Data was not available to review specific child protection training for level 2 and level 3. School nurses told us that they had been asked to participate in child protection work beyond their competencies, for example, in undertaking assessments or attending serious case reviews.
- There was a system in place to ensure that health visitors or school nurses, depending on the child's age, were notified when a child or young person had attended the emergency department. However, staff told us the forms could take a week to reach their team

**Incidents**

- The trust had reported 1,315 incidents to the NRLS from January 2014 to January 2015. The majority (97%) of these incidents were low risk or no harm incidents. Moderate incident accounted for 2% of all incidents and serious incidents (severe harm or death) 1%.
- There 37 serious incidents 18 Serious Incidents were reported by inpatients, 14 for community health services for adults and five for community health services for children, young people and families. The majority had been for pressure ulcers (grade 3 and 4) and falls with harm. These incidents had been investigated through root cause analysis and the learning implemented.
- Staff were reporting incidents but some staff told us they did not know how to report incidents and some staff were being discouraged from reporting incidents by some managers specifically in inpatient and children, young people and families services. Many staff did not identify near misses or errors or inappropriate inpatient admissions as incidents, and told us that they received feedback on incidents they had reported. There was limited evidence that lessons learnt were being effectively shared within and across services.

**Staffing**

- Staffing levels were a concern in all areas and there were high vacancy rates. Many staff reported working long hours to provide appropriate care to patients. Many community teams operated a system of prioritising patients or had scaled back the services they offered. Waiting lists were longer in places and in children, young people and family service staff had identified they were unable to respond to identified patient risks. Agency staff were being used in inpatient services and staff worked flexibly to ensure continuity of care. However, in

# Summary of findings

Buckinghamshire Community Hospital, there were agency staff on duty without permanent staff and this was increasing risks to patients. The trust was actively recruiting staff but had described this as a challenge.

**Are services at this trust effective?**

**Requires improvement**

Overall we rated effective in the trust as 'requires improvement'. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital, Amersham Hospital and the provider report for Buckinghamshire Healthcare NHS Trust (2014). Please also refer to the community health services report for children, young people and families, adults, inpatient services and end of life care.

Acute services

In the emergency department patients were treated according to national evidence based guidelines and clinical audit was used to monitor standards of care. There were good outcomes for patients and mortality rates within the trust were within the expected range. Seven day services were developing and were in place for patients requiring emergency care. End of life care for patients had improved and more patients were receiving care according to national standards, but this care was not being monitored effectively to identify areas for further improvement.

Community health services

The use of national evidence based practice and the audit of care was not consistent practice. Community adult and end of life care services were rated as 'good'

**Evidence based care and treatment**

- Staff used national guidelines, for example, from NICE, and relevant Royal Colleges to determine care and treatment in adult community services and community end of life care. Some national guidelines were available in community inpatient services but these were not always used correctly. There was a number of policies and procedures in community children, young people and families and practice was in consistent, where national guidance existed, these were not always followed.

**Patient outcomes**

- Patient outcomes were not appropriately developed or monitored in children, young people and families or in community inpatient services where patients did not have goals identified for rehabilitation. Patient outcome measures

# Summary of findings

were developed and monitored in adult community services. Outcome measures were developed for goal orientated rehabilitation and in cardiac services. Although similar to other trust, outcome scores were below the national average for measures for stroke and intermediate care.

- The trust had contributed data about end of life care to the national minimum data set. For the national care of the dying audit 2013/14. The trust had not achieved five of the seven organisational key performance indicators (KPIs). The trust was below the England average for the majority of the clinical indicators of care although was not an outlier.

**Multidisciplinary working**

- There was good multidisciplinary team across adult community teams and the end of life care. Staff liaised effectively in community teams, with acute services and GP practices to share information about patients particularly those with complex care needs. There was not effective multi-disciplinary working in all community inpatient services and there were insufficient therapy services to support rehabilitation over seven days. The coordination of care pathways in children, young people and family services to share information or liaise with other agencies, such as GP surgeries, midwives and across acute hospital care, were inconsistent.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Staff followed consent procedures appropriately. However, this did not happen correctly in inpatient community services. We found example's where patients had not given their consent, or were not asked their consent or asked about sharing information about them. Staff knowledge and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards was variable. Many staff had not had attended training that was available and some staff that had attended training did not demonstrate appropriate levels of knowledge.

**Are services at this trust caring?**

Good

Overall we rated caring in the trust as 'good'.. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital, Amersham Hospital and the provider report for Buckinghamshire Healthcare NHS Trust (2014). Please also refer to the community health services report for children, young people and families, adults, inpatient services and end of life care.

Acute services

# Summary of findings

Care had improved in the emergency department and for patients receiving end of life care. Though staff were still busy, the need to find the time and provide compassionate care and support was acknowledged. Patients received compassionate care and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care and they received good emotional support from staff.

Community health services

Staff provided caring and compassionate services and involving patients in their care and treatment. However, we rated caring in community inpatient services as 'requires improvement'

**Compassionate care**

- Staff were caring and compassionate, and treated patients with dignity and respect. Staff demonstrated encouraging, sensitive and supportive attitudes towards patients taking their needs and preference into account. An holistic approach to patient care was observed in the community end of life care services.
- However, there were some issues highlighted in community inpatient services. Overall staff interactions with patients were positive but there were concerns that about patient privacy, dignity and confidentiality. There were also examples where staff and patient interactions needed to improve, in terms of staff attitude, response to call bells and responding to patients needs and wishes.

**Understanding and involvement of patients and those close to them**

- Patients were involved in developing the care plans, treatment and goals and staff took time to explain their care and treatment in the way in which the patient could understand.
- In community inpatient services patient discussions were not always recorded to confirm these discussions were happening. There were examples, where relatives told us they had not had discussions important care and treatment decisions. This included one example where relatives had not been told about end of life care.

**Emotional support**

- Patients told us they received good emotional support from staff. Psychological support was available in children, young people and families services, for adult patients receiving neuro-

rehabilitation services, and was sensitively considered for patients who might be anxious or distressed having end of life care. Pastoral care was available in community inpatient services

**Are services at this trust responsive?**

Requires improvement

Overall we rated responsive in the trust as ‘requires improvement’. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital, Amersham Hospital and the provider report for Buckinghamshire Healthcare NHS Trust (2014). Please also refer to the community health services report for children, young people and families, adults, inpatient services and end of life care.

Acute services

Patients continued to have long waiting times in the emergency department but they did not have long waits on trolleys or in the corridors. Rapid discharge for end of life care was being supported by specialist palliative care nurses, but the trust was still not monitoring patients preferred place of death for end of life.

Community health services

Overall we rated responsive as ‘requires improvement’. Services were being planned effectively to meet the needs of people, respond to patients individual needs and ensure patients received the right care at the right time. We rated responsive for community end of life care as ‘good’ which was a services that was developed to meet the needs of people.

**Service planning and delivery to meet the needs of local people**

- The trust was at different stages of services planning and delivery across community service s to meet the need of local people. Adult community services had focused on the integration of acute, community and primary care and were developing services, such as, rehabilitation and intermediate care in line strategy. Other services were still planning. Integrated services in end of life care were being planned and a strategy and action plan was under consultation . There was an inpatient review of community services to identify different models of care which would not always involve inpatient stays but would use community and day hospital facilities. Children’s, young people and families services were not being planned or delivered based on service demands and only operational targets were being used.

**Meeting needs of people in vulnerable circumstances**

- Community services were prioritising the needs of people in vulnerable circumstances, some of this was planned but sometimes this happened as necessity. For example, care was coordinated effectively for to manage risks for end of life care patients. There were services for older people to support medical assessment b by a geriatrician but avoid hospital admission. In children, young people and families services identified children with complex needs, requiring early intervention and looked after children as priorities . However, this has meant that the focus on preventative work was limited and had not happened.
- In community inpatient services there were frequent delays for referrals made to the learning disability nurse specialist, and also for mental health.

**Access to right care at the right time**

- Access to the right care at the right time was not always being delivered. There were long waiting times for patients requiring community adult services, particularly for rehabilitation services and chronic pain management. Where patients were waiting for treatment, eligibility criteria were used and urgent cases were prioritised . The trust was developing a single point of access for reablement services across health and social care to improve access to services.
- Child health clinics were held regularly in children's centres, health centres, hospitals, community centres and surgeries, and parents were able to access these as they wished. Patients had good access to health visitors and could ring directly for appointments. Waiting lists for therapy services were within 18 weeks. However, the trust was not meeting the initial assessment within 28 days target for looked after children , or health visiting targets for universal antenatal visits. The waiting list for the learning disability service was not meeting the 18 week waiting time target.
- Specialist palliative care series for community end of life care were provided 24/7. This was either provided through the clinical nurse specialist or hospice teams. The service worked flexible to ensure patients were seen at a time that was suitable for them and the Patient information could be shared across health and social services using the Buckinghamshire Coordinated Care Record at any time.
- Patients in hospital for rehabilitation had appropriate arrangements if they required emergency care. However, patients were sometimes being admitted inappropriately with

complex care needs and staff did not have the skills or experience to provide this care and they were not able to be reviewed promptly by a doctor if the GP had already visited the hospital on that day. Patients had long waiting times to be admitted for rehabilitation in the community hospitals and were delayed further delays by inappropriate admissions to community hospital from the acute hospitals.

**Learning from complaints and concerns**

- How complaints were handled varied across community services. Staff were responding to patient concerns as part of their care needs, but complaints were not recorded appropriately so complaints in community end of life care services could not formally be identified. There was not a consistent way of logging, investigating, responding to and learning from complaints in children, young people and families services. Most staff did know the process for handling complaints and people we spoke with did not know how to make a complaint or raise concerns. Where concerns had been raised, these were not always addressed.
- Complaints were handled appropriately in community adult services and there were lessons learnt and improvement to services as a result.

**Are services at this trust well-led?**

**Requires improvement**

Overall we rated well led in the trust as 'requires improvement'. For specific information , and our previous findings on well led, please refer to the Buckinghamshire Healthcare NHS Trust provider report (2014).

The trust had improved and developed services in emergency care and end of life care which had both been of significant concern at our last inspection in March 2015. Community services varied in their service developments. The trust clinical strategy was around the integration of acute, community and primary care service. This was developing in adult community services and under strategic development in end of life care and community inpatient services. The strategy was undeveloped in children, young people and families services.

Governance arrangements and risks needed to be better managed across all community services. The leadership of the children, young people and families services was 'inadequate' with some managers at team and operational level demonstrating inappropriate behaviours to manage risks and ensure and open and transparent culture. Staff engagement needed to improve to ensure priorities and the pace of change were agreed, understood and implemented.

**Vision and strategy for this service**

- During our inspection in March 2015 we identified that the trust had developed the Buckinghamshire Health & Social Care Operational Resilience & Capacity Plan 2014/15. Identified how the trust was working with its partners to improve emergency and elective care. There were joint initiatives to improve planning and capacity across the ambulance, primary care, community and acute services across Buckinghamshire. There had been significant services in emergency care that had led to improvements in the emergency care pathway in Stoke Mandeville Hospital. The end of life care strategy was being developed in consultation with patients.
- The initial strategy for Community services in 2010 was called "Transforming Community Services" and identified an integrated range of services across acute and community care services. The strategy had not fully materialised although some elements of integration in adult community healthcare team were apparent. The trust 2020 strategy was called "Working Together for Excellent Care In Buckinghamshire". Central to this strategy was the need to integrate care across acute, community and primary care to provide "right care, right place, right time, first time".
- In adult community services, many elements of the 2020 clinical strategy were being implemented. This included the integration of the community falls and bone health service, the development of a single access point for referrals, adult community teams working closely with GPs, and closer working with social care reablement teams. There was also evidence of engagement with new technology, using telehealth to bring care into people's homes and arrangements for mobile working were available to many community staff.
- A new end of life care strategy had been developed with staff and patients to support seamless integrated care across acute, community and primary care services based on the needs of individuals. The communication of the changes identified within the strategy, however, needed to improve as staff were not aware of priorities and had not had some relevant training.
- 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. Plans aimed to reduce inpatient facilities to increase the focus on community

and day services. Staff were not aware of the details of these plans and had not yet been involved in their development. The children, young people and family services did not have a strategy and only operational targets, some determined nationally, existed.

**Governance, risk management and quality measurement**

- The trust had an integrated management structure. This linked the hospital and community services across the seven sites under three clinical divisions for integrated medicine, surgery and specialist services. Within these divisions there were 28 service delivery units across acute and community services. There were trust committees to manage quality, risk and performance, and divisions had monthly clinical governance meetings for staff to review complaints, incidents, audits and guidelines. There were comprehensive quality dashboards at corporate, division, service delivery unit and ward levels, and quality and performance indicators were displayed on wards for patients to see. These arrangements ensured that responsibilities were clear, quality and performance were integrated and continually reviewed, and problems were detected, understood and addressed.
- Clinical staff were engaged as leaders and worked with managers to lead the divisions and service delivery unit. However, consultant medical staff told us that, although they were paid for leadership roles, they did not have protected time and this made fulfilling their responsibilities more difficult. Staff also expressed some concerns about working across divisions and across hospital sites to manage risks. It was considered an unresolved situation but one that continued to have an impact on patient care because of delays in accessing treatment and specialist advice.
- The NHS Staff Survey 2014 identified that the trust in the top 20% of trusts for reporting errors, near misses or incidents. The trust incident reporting had improved from the previous year. Staff received feedback from incidents but sharing information and learning from incidents was under developed and needed to improve.
- Governance and risk processes in community services were underdeveloped. Quality dashboards were used but performance indicators were not specific to community services and in some areas, these were underdeveloped. Risks

were not being appropriately identified and escalated to the trust board. In children, young people and families services, individuals were actively dissuading staff from raising serious concerns.

- Clinical policies and procedures based on national guidelines were being used in community services. However, these were underdeveloped and not ratified or used appropriately in children, young people and families services, and, where available, not consistently followed in community inpatient services. There were some also policies that the trust had adapted for community services which were inconsistent with the action that might be taken in acute services for the same clinical condition. For example, the clinical response to the national early warning score regarding a patient's whose condition might deteriorate. There were also policies that were difficult to implement in community setting, such as the administration of certain medicines by two staff when staff were lone workers. There was limited evidence of clinical audit to monitor and evaluate practice.

**Leadership of service**

- There had been significant changes in the trust leadership in the previous year. A new trust chair had been appointed to start in March 2014, and a new chief nurse was April 2014. The medical director, chief operating officer and director of human resources were all new appointments within the past 18 months. Two new non-executive directors were to be appointed in April 2014. The leadership was forming relationships and developing new ways of working.
- At the time of our inspection in March 2015, the chief executive officer had announced that she was leaving the trust at the end of March 2015. The chief operating office r/ deputy chief executive had been identified as the interim chief executive officer
- The leadership team performed walkabouts around the hospital to talk to staff and review quality and safety, although some staff commented that the frequency of these was not sufficient for them to have met or seen members of the team. Many staff, however, commented on the visibility and accessibility of the chief executive and director of nursing. Staff valued the impact of the changes and the improved communication. The trust had introduced ward and clinical leadership programmes to ensure the engagement of clinicians in developing strategies for improvement.

- The leadership of the emergency and end of life care services had improved. There had been significant changes in the development of these services. The leadership within community services varied.

**Culture within the service**

- The culture had improved in the emergency department. Staff had had team building support and had worked to lead the pace of change. The hospital culture was also changing so that the emergency care pathway was being 'owned' by the hospital rather than the emergency department, although this still needed to improve. For end of life care services, staff throughout the trust expressed a desire to ensure that patients at the end of their life were provided with the best possible care.
- Community services staff described a culture where they lacked staff and resources and did not feel like a priority for the trust. They identified that they worked effectively within teams to ensure that patients received the best possible services but were working longer hours to achieve this. The emphasis however, across many teams, particularly in community end of life care, was to provide holistic care. In children, young people and families services staff described a culture of feeling "pressured" and sometimes "bullied" by some staff. They described situations that they were made to do where they did not feel they had had the training, support or competence to undertake.

**Public engagement**

- Public and patient engagement events had taken place 'called One Chance to get it right'. This had a focus on achieving good quality care for people who are approaching the end of life whilst in the trusts care. Over 50 people had attended and following this, volunteers had become involved in developing the new end of life strategy to be launched in October 2015.
- There were fewer examples of public engagement in community services. In adult community services surveys and focus groups were being used effectively to plan services but this was limited elsewhere.

**Staff engagement**

- As in the previous year, the NHS Staff Survey (2014) identified that the trust was in the bottom 20% of trusts nationally for engagement and staff contributing to improvement at work. Work pressures, motivation and support from managers was in

the lowest 20% of trust. We found, in contrast, that staff engagement had improved significantly in the emergency department. Service changes were described as “clinically led” and the pace of change reflective of the effectiveness of staff engagement. However, staff engagement needed to improve to further develop and ensure good communication around the end of life care strategy.

- In community services, staff were increasing being involved in new initiatives, but there remained the overwhelming feeling that they were isolated, rather than integrated services within the trust.

**Innovation, improvement and sustainability**

- The trust could demonstrate significant innovation in emergency care services in the last 12 months and in developing its end of life care strategy. Community services could demonstrate many examples of innovative care, with the aim of developing fully integrated care services. However the planning and coordination of these services across the trust and health and social care system needed to improve.

# Overview of ratings

## Our ratings for Stoke Mandeville Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Medical care | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Surgery | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Critical care | Good | Good | Outstanding | Good | Good | Good |
| Maternity and gynaecology | Good | Good | Good | Good | Good | Good |
| Services for children and young people | Good | Good | Good | Good | Good | Good |
| End of life care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Outpatients and diagnostic imaging | Good | N/A | Good | Requires improvement | Requires improvement | Requires improvement |
| National spinal injuries centre | Good | Outstanding | Outstanding | Good | Good | Good |
| **Overall** | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |

# Overview of ratings

## Our ratings for Wycombe Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Surgery | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Critical care | Good | Good | Good | Good | Good | Good |
| Maternity and gynaecology | Good | Good | Good | Good | Good | Good |
| Services for children and young people | Good | Good | Good | Good | Good | Good |
| End of life care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Outpatients and diagnostic imaging | Good | N/A | Good | Requires improvement | Requires improvement | Requires improvement |
| Overall | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |

## Our ratings for Amersham Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Requires improvement | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Outpatients and diagnostic imaging | Good | N/A | Good | Requires improvement | Requires improvement | Requires improvement |
| Overall | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |

# Overview of ratings

## Our ratings for Community health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Community health services for children, young people and families | Requires improvement | Requires improvement | Good | Requires improvement | Inadequate | Requires improvement |
| Community health services for adults | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Community health inpatient services | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Community end of life care services | Good | Good | Good | Good | Good | Good |
| Overall | Requires improvement | Requires improvement | Good | Requires improvement | Inadequate | Requires improvement |

## Our ratings for Buckinghamshire Healthcare NHS Trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Overall | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |

### Notes

**Notes: Stoke Mandeville Hospital**

1. This ratings grid is form March 2014 but includes updated ratings from an unannounced focused inspection in urgent and emergency care service and end of life care services (March 2015)
2. We are currently not confident that overall CQC is able to collect enough evidence to give a rating for effectiveness in outpatients
3. The National Spinal Injuries Centre does not have an overall rating as outstanding as planning for the sustainability of the service in terms workforce planning has not happened and the learning from this services is not effectively shared across the trust.
4. The effectiveness of services were judged to be good overall

**Notes: Wycombe Hospital**

1. This ratings grid is from March 2014 but includes updated ratings from an unannounced focused inspection of end of life care services (March 2015)
2. We are currently not confident that overall CQC is able to collect enough evidence to give a rating for effectiveness in outpatients

# Outstanding practice and areas for improvement

## Outstanding practice

- Community adult health services were available to patients 24 hours a day, seven days a week. This included nurses caring for patients in their homes at night.
- In the integrated cardiac rehabilitation service, new technology was used to improve pathway tracking of patients and provide outcome data. Staff told us the information generated as a result of this project helped them to improve the services they offered to patients. The new systems and technology, they said, had improved uptake of treatment from 52% to 82%.
- The trust provided a community diabetic service which offered two hour clinics twice a week for non-English speaking patients, and provided interpreters. Clinics could be accessed by appointment or drop in. There was also a three week education session provided over Ramadan for healthcare professionals and a drop-in programme for patients who had diabetes to help patients make adjustments to their medication while fasting.
- Staff from the respiratory team told us there was a single point of access seven days a week for specialist nursing services provided by their team. Patients, GPs, community nurses and staff from the hospital's inpatient wards could ring the team on a dedicated phone number for advice and support.
- Patients were given an individualised, multidisciplinary risk assessment regardless of the service they used. For example, patients had assessments as required for mobility, nutrition, pressure ulcers, mental and emotional wellness, occupational therapy, and home environment. We saw evidence of this in almost all the patient records we looked at.
- The trust contributed to the development, launch and use the Bucks Coordinated Care Record. This is a county-wide electronic end of life register that GP practises, NHS Trusts and hospices have signed up to use to coordinate care and services.
- The specialist palliative care nurses provided a daytime service with telephone advice and support out of hours. Face to face support was available out of hours from the district nurse team. The children's team worked flexibly and provided a 24 hour service when a child was approaching the end of their life.
- 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 trust MUST take to improve

The trust must ensure

- Patient risk assessments and the documentation that supports them are routinely completed in the Emergency Department.
- There is effective clinical engagement for a hospital wide focus to patient flow and escalation processes and this is monitored.
- There are timely GP discharge summaries following a patient admission to the Emergency Department.
- There is a timely replacement for the Liverpool Care Pathway and all staff follow the current interim policies.
- Staff complete the end of life care plans (Hearts and Minds – end of natural life) appropriately to NICE guidelines for holistic care and they are followed.
- All staff consistently and appropriately complete the DNACPR forms and discussions between patients and relatives are recorded in patient records.
- The overhead lighting lamps in the hospice are replaced to reduce the risk to patients of contact with hot surfaces.
- Staffing levels in the mortuary are reviewed give staff adequate rest time between shifts and to reduce the levels of lone working.

# Outstanding practice and areas for improvement

- Mortuary staff have appropriate equipment for bariatric (obese)patients to reduce the risk of harm to staff from inappropriate manual handling.
- Deceased patients are clearly and appropriately identified when being transferred from wards to the mortuary.
- All staff involved in end of life care can identify a patient at the end of life (12 months) to ensure that referrals to the specialist palliative care team are made in a timely manner.

Community adult services

- There are effective operation of systems designed to enable it to identify, assess and manage risks relating to patients which arise from incidents and near misses.
- There are sufficient numbers of suitably qualified staff in all community teams and ensure safe caseload levels.
- The suitability of premises and facilities for the head injuries unit in Cambourne.
- There are suitable arrangements for the privacy and dignity of patients using the multidisciplinary day assessment service (MuDAS).
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from inaccurate patient records or records which cannot be located promptly when required.
- Staff receive appropriate training on the Duty of Candour and the Mental Capacity Act 2005.
- Community staff and managers have clinical supervision and support to undertake their role.

Community children and young people services

- Staff are able to freely raise any concerns about being unable to deliver services safely and that this is heard and acted on by management.
- Staff use the incident reporting system to report concerns
- Staff have appropriate safeguarding and mandatory training
- Ensure there are mechanisms in place to obtain feedback from people who use services.
- Staffing levels are assessed and reviewed using an evidenced based tool and meet recommended guidelines.
- Staff can appropriate identify and respond to patient risks
- All pregnant women receive a universal antenatal contact with a health visitor.
- Multi-disciplinary team working is effective and pathways of care are coordinated and, where necessary, children receive early support.
- There is an audit programme to monitor the quality and safety of services.
- Children on the learning disability waiting list are appropriately managed
- Consistently log, investigate, respond and learn from complaints in the community children and young people's services.
- Staff fully understand the Mental Capacity Act 2005 and the deprivation of liberty safeguards.
- There is a service strategy and services are planned effectively around prevention and local need.
- The leadership concerns are fully investigated and action is taken to ensure and open, transparent and supportive culture exists in the service.
- Governance arrangements are improved.
- Patient engagement and feedback is improved across the service
- Staff engagement is improved across the service.
- Budgetary constraints do not adversely affect the care and treatment of children, young people, and parents and carers.

Community inpatient services

- 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 to use the information to improve the service provided.
- 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 accident 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.

# Outstanding practice and areas for improvement

- 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

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 |
|---|---|
| | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>**Staffing**<br><br>**How the regulation was not being met:**<br><br>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.<br><br>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 |
|---|---|
| | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br><br>**Supporting workers (staffing)**<br><br>**How the regulation was not being met:**<br><br>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.<br><br>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. |

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# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>**Respecting and involving people who use services (good governance)**<br><br>**How the regulation was not being met:**<br><br>There were unsuitable arrangements for ensuring patients' dignity, privacy and independence.<br><br>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<br><br>**Records (good governance)**<br><br>**How the regulation was not being met:**<br><br>Patient records were not always accurate and were not always securely stored.<br><br>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 |
| --- | --- |
| | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br><br>**Assessing and monitoring the quality of service provision (good governance)**<br><br>**How the regulation was not being met:** |

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# 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.

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 |
|---|---|
| | Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment<br>**Safety, availability and suitability of equipment (premises and equipment)**<br>**How the regulation was not being met:**<br>The trust did not have suitable arrangements to protect patients and others who were at risk from the use of unsafe equipment.<br>Mortuary equipment for bariatric patients<br>Overhead lighting lamps in Florence Nightingale Hospice<br>Regulation 16(1)(a)(2) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |