Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Heatherwood Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Accident and emergency	Good
Medical care	Good
Surgery	Good
Outpatients	Requires improvement

Summary of findings

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Summary of findings

Overall summary

Heatherwood Hospital is an acute location run by Heatherwood and Wexham Park Hospitals NHS Foundation Trust. The hospital provides the following services: medical rehabilitation, orthopaedic elective surgery, short stay surgery, minor injuries unit, theatres and outpatients departments. There is no Accident and Emergency at this site.

We inspected the following regulated activities for which the hospital is registered: treatment of disease, disorder or injury, diagnostics and screening, and surgical procedures.

Patient needs were assessed and care was planned and delivered to meet those needs. Patients were communicated with and felt involved in their care and in decision making. All feedback received from patients was positive; this applied across the multidisciplinary team. Patients were provided with appropriate information at all stages of their care and treatment.

Although patients received safe care and were protected from risks, incidents were not always reported appropriately and there was some evidence that the learning from incidents needed to improve (for example in relation to falls). In addition, the trusts own audits found that the World Health Organisation checklist was not being completed robustly at this site. Hospital areas visited were clean, and staffing levels were maintained for the majority of shifts.

Patient care and treatment were planned and delivered in line with legislation and best practice. Patient records were kept up to date and were updated in a timely manner. Audits were undertaken to monitor care and outcomes, and, where required, action plans were implemented to improve care. Appropriate equipment was not always available to reduce the risk of harm (for example to prevent falls). This is a breach of Regulation 10 regarding the safety and suitability of premises. There were systems in place to ensure that staff had undertaken mandatory training, but not all staff had received an annual appraisal.

All wards and departments at Heatherwood Hospital were managed as part of the three divisional structures based at Wexham Park Hospital. Governance arrangements and support from senior staff were communicated via the lead nurses for the relevant division, who ensured that reporting and feedback for Heatherwood Hospital wards and departments were fed into the relevant committees.

During our inspection, it was confirmed that the minor injuries unit and ward 8 were due to close in the near future. The plan was for the services provided by the unit and ward 8 to continue but to be provided by other providers and within the community. This situation had an impact on staff working in the affected areas, although they all continued to be committed to the delivery of high standards of care in the interim.

During our inspection, we spoke with patients and their relatives and to members of the public who shared their experience with us at a listening event the week prior to the inspection. We spoke with 10 patients and 15 members of staff.

Staffing

Some wards and departments we visited had staff vacancies. These were covered by either bank or agency staff to ensure patient safety and that the needs of patients were met. There were some occasions when the required number of staff was not available for a shift; this could have an impact on patient safety. Wards and departments at Heatherwood Hospital were supported by on-site medical staff and a range of allied health professionals. These staff members were based on the wards and worked as a cohesive team with the nursing staff. All staff we spoke with felt that joint working with the multidisciplinary team ensured positive outcomes for patients.

Cleanliness and infection control

All the areas of the hospital that we visited were clean and free from clutter. Alcohol hand disinfectant was available on entry to wards and departments, at the patients' bedsides and in other key points, enabling good access for staff and visitors. However, this was not the case in the outpatient departments. We noted that audits

Summary of findings

of staff compliance with hand hygiene were between 89% and 100% in surgical areas. The areas we visited displayed the results of cleaning audits, which were above 90%.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Patients received safe care and were protected from risks. Incidents were not always reported appropriately, and there was some evidence that learning from incidents to improve care was not robust (for example in relation to falls) and that appropriate equipment was not always available to reduce the risk of harm. The areas visited in the hospital were clean. Staffing levels were maintained for the majority of shifts. There were systems in place to ensure that staff had undertaken mandatory training.

Are services effective?

Good

Patient care and treatment were planned and delivered in line with legislation and best practice. Patient records were kept up to date and were updated in a timely manner. Audits were undertaken to monitor care and outcomes, and, where required, action plans were implemented to improve care

Are services caring?

Good

Patients were communicated with and felt involved in their care and in decision making. All feedback received from patients was positive; this applied across the multidisciplinary team. Patients were provided with appropriate information at all stages of their care and treatment.

Are services responsive to people's needs?

Requires improvement

Although we found the Minor injuries unit, the medical wards, and surgery at this site to be responsive, we found significant concerns surrounding the provision of outpatients services. There are unacceptable waiting times for certain conditions, and 25% of appointments had been cancelled.

Are services well-led?

Good

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Summary of findings

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

Accident and emergency

Good

The minor injuries unit provided safe and effective care for patients. There were sufficient numbers of staff, with appropriate qualifications, skills and experience to ensure that patient needs were met. The majority of patients were seen within four hours. The patients and their families with whom we spoke were very positive about the care and treatment they received in the department.

Medical care (including older people's care)

Good

Patient's needs were cared for by a multidisciplinary team of healthcare professionals who ensured joint working and communication throughout the patient journey. Systems for identifying risk and reporting incidents did not always lead to actions being taken to protect patients from harm (for example from falls). A lack of access to a range of appropriate equipment prevented staff from being able to ensure that patients were safe.

Surgery

Good

Patients received safe and effective care. Staff were aware of how and when to report incidents, and they confirmed that they had feedback on these after local investigation and learnt lessons to improve patient care. Care was delivered in line with national standards and evidence-based practice. Staff were trained appropriately to deliver care to meet patient needs. Multidisciplinary staff working was effective in achieving patient outcomes and planning discharge from hospital. Patients were positive about all aspects of the surgical pathway and about all groups of staff involved in their care and treatment. Monitoring was undertaken and action plans were in place to address areas of non-compliance.

Outpatients

Requires improvement

We found that some improvements were required to keep the outpatient service safe and effective for people at Heatherwood Hospital. These included better infection control and systems to ensure that people received treatment in a timely way, as well as better performance in arranging outpatients' appointments in line with the trust's own policies.

We found that the hospital was good at caring for people on a one-to-one basis. Most front-line staff were respectful and considerate. Insufficient work had been done to improve the booking and appointments systems, waiting times and the cancellation of clinics. Improvements were required to ensure that the service was well led. There was good leadership at a local level, but it needed to be improved at senior manager level.

Summary of findings

What people who use the hospital say

The Friends and Family test had been introduced in April 2013 to give patients the opportunity to offer feedback on the quality of care they had received and whether they would recommend it to their friends and family. Heatherwood Hospital scored above the national average for inpatient in December 2013 with a score of 88 against a national average of 71. The response rate for these areas was 77.65% compared to 28.5% nationally.

In the A&E department Friends and Family test, the hospital's minor injuries unit scored well above the national average for the response rate and the score consistently. In December 2013 they scored 71 against a national average of 56, with a response rate of 16.6% against a national average of 15.3%.

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

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

The NHS choices website had 50 reviews and gave Heatherwood Hospital scores of 4.5 stars out of 5 overall. There were eight positive comments which were rated five star and two comments which were rated as one star.

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

The Patient-Led Assessment of the Care Environment (PLACE) scored Heatherwood Hospital below 90% in three of the four metrics. These include cleanliness, food and facilities; the lowest at 81% for 'Food'. Privacy, dignity and wellbeing was the only area that was above 90% with a score or 96.5%.

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

Areas for improvement

Action the hospital MUST take to improve

- The trust must take steps to improve the booking and appointments system, waiting times and the cancellation of clinics to prevent delays and to improve access to treatment.
- Relevant departments must have access to staff trained to meet the needs of vulnerable patients, such as those with a learning disability or dementia
- The hospital environment and facilities must be maintained to a suitable standard
- The trust must ensure that there are sufficient staff to meet the needs of patients. This should be determined by patients' assessed requirements and should be in line with the use of recognised staffing tools.
- Communication with patients must be improved when delays to clinic appointments lead to increased waiting times.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- All comments received from patients were very positive about the care they had received in the hospital.
- Pre-operative assessment processes identified potential risk factors for patients undergoing elective surgical procedures.
- Staff were proud of the care and treatment they provided to patients.
- Multidisciplinary working was very good in all wards and departments.
- Patients were involved in their care and in decision making.
- Patients had sufficient information from which to give informed consent.

Heatherwood Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Outpatients

Our inspection team

Our inspection team was led by:

Tracey Halladay, Care Quality Commission

Chair: Kathy McLean

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Nick Irwin – Care Quality Commission, Dr I Rodrigues, Dr B Graf, Dr I Higginson, G Buck – Expert by Experience, Sally Spencer – Registered Nurse, Madeline Wang – Patient and Public Representative

Background to Heatherwood Hospital

Heatherwood Hospital provides services to people living in the Ascot area as well as some trust-wide services, including: minor injuries unit, medical and stroke rehabilitation, elective orthopaedic surgery and a range of outpatient departments.

Heatherwood Hospital was inspected in May 2013. Non-compliance was found in the following areas: care and welfare and records.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Accident and emergency
- Medical care (including older people's care)

Detailed findings

- Surgery
- Outpatients.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 13 February 2014 and an unannounced visit on 20 February 2014. During the visits, we spoke with a range of staff in the hospital: nurses, doctors, physiotherapists, occupational therapists and pharmacists.

We talked with patients and staff from all areas of the hospital, including the wards, operating theatres, outpatient departments and the minor injuries unit. We observed how people were being cared for and talked with carers and/or family members and reviewed patients' personal care or treatment records. We held a listening event at which patients and members of the public shared their views and experiences of the hospital.

Good

Accident and emergency

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

Information about the service

Heatherwood Hospital has a minor injuries unit (MIU) that is open seven days a week from 8am to 10pm. The unit is managed and led by nurses who hold advanced practitioner qualifications in emergency care. The MIU sees an average of 300 patients a week, including both adults and children. Before our inspection, we reviewed information from, and about, the trust. During our inspection, we spoke with patients and staff and reviewed information from comment cards that were completed in the waiting area.

Summary of findings

The MIU provided safe and effective care for patients. There were sufficient numbers of staff, with appropriate qualifications, skills and experience to ensure that patient needs were met. The majority of patients were seen within four hours. The patients and their families with whom we spoke were very positive about the care and treatment they received in the department.

Good

Accident and emergency

Are accident and emergency services safe?

Good

Safety and performance

We spoke with four staff in the MIU who told us that the service provided treatment for people with minor illnesses and injuries. All of the nursing staff held advanced nurse practitioner qualifications in emergency care; this meant that they had additional training to enable them to assess and treat people with minor injuries without needing medical input. The nursing staff were independent in their assessment and treatment of patients and had access to clinical guidelines and trust policies and protocols to support their decisions. If the nurses required additional clinical advice, they were able to contact the appropriate medical staff (for instance in the case of a complex fracture). Staff were able to view patients' X-rays on a computer screen that was linked to the Wexham Park Hospital accident and emergency department (A&E); this made it quick and easy for staff to share the X-ray and discuss any concerns and the most appropriate treatment with a member of medical staff.

Learning and improvement

Staff were all aware of the incident-reporting system known as Datix. There were few incidents reported in the department, but these would be discussed within the team to learn and improve where required. Staff told us that findings had been fed back to them from any audits that had been undertaken of patient notes and child protection procedures.

Systems, processes and practices

There were reliable systems, processes and practices in place to keep people safe. Daily checks of emergency equipment were undertaken according to trust policy to ensure that all equipment was ready for use in the event of an emergency. Monthly hand hygiene audits were carried out; these showed a compliance rate of 85% in October 2013, rising to 91% in December 2013.

Monitoring safety and responding to risk

The MIU was not able to treat more serious injuries. Staff told us that they carried out triage of patients to determine whether they needed to be advised to attend A&E to prevent delay to their treatment. We observed the receptionist taking details of a child who had fallen; the member of staff asked the child and the mother if the child had bumped their head, as this may have indicated a need for them to be seen more urgently. When the MIU was very busy, staff told us that they would check the waiting area to ensure that priority was given to the most urgent cases and treatment not delayed. Review of the risk register for the trust division that it reported to did not raise any concerns related to the MIU.

Anticipation and planning

Staff in the MIU were trained to undertake resuscitation in the event of an emergency. Any patient who required more urgent treatment was referred to Wexham Park Hospital A&E department. There was a trust protocol for the transfer of patients and staff told us that they adhered to this and would not hesitate to call an ambulance if required.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

There was not sufficient evidence to rate this service.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients' privacy and dignity were respected; we observed staff knocking on the doors of consultation rooms prior to entering them. One patient had to have some clothing removed so that a plaster cast could be applied, and staff ensured that their dignity was maintained by providing a dignity gown for them to wear when they went home.

Involvement in care and decision making

Patients were involved in their care and were able to take part in decision making about their care in an informed

Good

Accident and emergency

manner. Many patients attending were children; in these cases, the parents we spoke with confirmed that they were happy with the care and information they were given.

Trust and communication

A parent commented on the excellent service they had received on a number of occasions when attending the MIU with their children. One teenage patient we spoke with commented that staff had treated them as an adult and had explained things to them. We saw that staff were able to show patients their X-rays so that they could understand the extent of their injuries. One patient was shown the 'before and after' X-rays of a fracture to their toe and commented that they could clearly see why it had been painful.

Emotional support

We received feedback from one patient who had attended the MIU and was complimentary about the attitude of staff and about how they felt reassured by the way in which they were dealt with.

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

(for example, to feedback?)

Good

Meeting people's needs

Patients' needs were met. One patient told us that staff had dealt with their injury "from examination to discharge in just over an hour". Staff provided mobility aids, such as crutches or protective shoes for foot injuries, when patients required them, and we heard staff advising patients on how to use these aids and for how long. For patients who required plaster of Paris to be applied, the MIU had a plaster room and staff were trained in how to apply a range of plaster casts. The department was equipped so that staff could undertake resuscitation in the event of cardiac arrest; however, any patient requiring a higher level of medical care or treatment would be referred to Wexham Park Hospital A&E, where a higher level of support and equipment was available.

Vulnerable patients and capacity

Children were protected from the risk of abuse as staff had been trained in safeguarding children to level 3 and had access to the safeguarding policy and procedure for reporting any concerns. We reviewed four sets of records for children under the age of 18 and saw that in all cases a safeguarding children form had been completed. Staff told us that they could refer any child of concern to the paediatric team, health visitor or duty social work team, depending on the degree of concern. On occasions when they had made referrals, they felt that the process had worked well. Staff told us that they sought verbal consent from patients for minor procedures such as suturing and taking blood.

Access to services

The MIU was open from 8am to 10pm, seven days a week. Patients requiring treatment outside these hours had to attend A&E at Wexham Park or at another local hospital. Patients were able to attend follow-up clinics run by the emergency department clinicians at Heatherwood Hospital. When we checked four records, we noted that dates for follow-up appointments had been documented. When patients returned for outpatient reviews at the fracture clinic, we saw that notes and X-rays had been collated and organised ready for the clinic, ensuring that access to the required information was timely.

Patients waiting to be seen in the MIU were subject to the same targets as those waiting for treatment in A&E. This information was provided as part of the trust-wide data for A&E waiting times, but staff told us that patients did not often have to wait for four hours or more, although on occasion this had occurred. The majority of patients were seen and discharged within one to two hours. This was supported by patient comment cards and by the patients we spoke with during our visit. One said: "It's all been very quick, less than two hours from arriving to X-ray, treatment, second X-ray and being able to go home."

Leaving hospital

The patients we spoke with confirmed that they were given all the relevant information they required on discharge from the MIU. This included information on follow-up appointments and taking pain relief. A range of information leaflets was available in the department to provide advice and guidance supporting what patients had been told by the staff.

Good

Accident and emergency

Learning from experiences, concerns and complaints

The department was viewed by patients and staff as providing good care and complaints were very rarely received.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

We were made aware during our inspection that the MIU would be closing and was due to transfer to the management of a new provider in April 2014. The new location would be close to Heatherwood Hospital, enabling continued local access to the service. Staff had been given the opportunity to transfer to the new provider but were anxious about the impact this would have on the team, as some staff had decided not to be part of the move.

Governance arrangements

Wards and departments at Heatherwood Hospital followed the governance arrangements for the relevant trust division with which each one was linked. Primary responsibility for these areas lay with the lead nurses for each 'care group' within a division: for instance, MIU was part of division C. The lead nurses visited their areas of responsibility at least once a week to provide support to the matrons and to hear any concerns. The lead nurse attended the specialty governance meetings, which were chaired by a clinician. These meetings reviewed all incidents, including serious incidents, and audit activity, and key aspects were then fed into the divisional governance and trust-wide governance meetings. We reviewed the minutes for June–October 2013; these did not indicate any concerns in MIU and demonstrated that incidents and learning from across the division were discussed to facilitate feedback to all wards and departments.

Leadership and culture

The MIU had a small number of staff who were committed to providing good care and treatment to patients and to working as a team in order to achieve this. The MIU was led and managed from Wexham Park Hospital A&E; this appeared to distance the staff from leadership and governance within the division. Some members of staff were to transfer to the new provider and told us that this had caused anxiety and uncertainty: they were proud of their department and felt uncertain about the future.

Patient experiences, staff involvement and engagement

Patients and the public were aware of the proposed changes to services at Heatherwood Hospital and expressed concerns to us at the listening events we held. These concerns were that people did not want to travel to a larger emergency department when they could receive prompt and good care and treatment in their local hospital. We reviewed data for complaints and there had been six formal complaints and two concerns raised with the Patient Advice and Liaison Service (PALS) in the last year.

Good

Medical care (including older people's care)

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

Information about the service

Ward 8 at Heatherwood Hospital provides rehabilitation for patients recovering from a stroke or other medical condition. Care and treatment are delivered through joint working between nursing, medical and allied health professional multidisciplinary teams.

Ward 8 was last inspected by the Care Quality Commission in May 2013. Non-compliance was found in the areas of records and infection control. During this visit, we checked to see whether our previous concerns had been addressed.

Summary of findings

Patients' needs were cared for by a multidisciplinary team of healthcare professionals who ensured joint working and communication throughout the patient journey. Systems for identifying risk and reporting incidents did not always lead to actions being taken to protect patients from harm (for example from falls). A lack of access to a range of appropriate equipment prevented staff from being able to ensure that patients were safe.

Good

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety and performance

The ward undertook safety audits on a regular basis in line with the trust's programme. These included elements of the Patient Safety Thermometer, such as monitoring falls and venous thromboembolism (VTE), pressure ulcers and hand hygiene compliance. The data was presented by the lead nurse for the division and reviewed at specialty governance meetings. Feedback was then provided to ward staff via the matron at ward meetings. The ward had a high number of falls, which was consistent with the division as a whole; we saw that this was recorded on the divisional risk register. Our review of the incidence of falls from August to February 2014 showed a range of three to nine falls a month, of which four were classified as 'major impact' and had resulted in the patient sustaining a fracture. We reviewed the records of one patient who had fallen on two occasions; the records confirmed that a review of the falls risk assessment had been completed after the falls. According to four patient records we reviewed, a range of risk assessments had been completed for falls, nutrition, manual handling, dementia and prevention of pressure ulcers. All these issues had been reviewed at regular intervals and any changes in risk documented.

Learning and improvement

Data on the number of falls in the month was displayed in the ward; this indicated that there had been four falls in the seven days leading up to our visit. Where an incident such as a fall was classed as a major incident, the matron and lead nurse were involved in an investigation to understand how the incident could have been prevented and to prevent further incidents. There had been a recent fall that was classified as a major incident; one member of staff told us that this had meant the matron had to present the investigation findings at a panel. The matron had fed back the findings to the ward staff. The investigation of a fall in October 2013 had been presented at the Patient Safety Group with the recommended learning that staff should follow the 'Essential Patient Care Following a Fall' flow chart.

We were concerned that the ward had high numbers of falls and asked staff what had been done to reduce these. Three staff were unsure about the different actions that had been taken and there seemed to be a reliance on one type of alarm, which was used for patients who would get up from their chairs. The staff said that there were not enough of these alarms but did not mention other types of device that could be used to alert them when patients may be at risk of falling. The ward layout was cited as one reason for the number of falls, since staff could not see the patients in the bays and side rooms from the nursing station or unless they were in a bay. We met the trust lead for falls who explained that one issue had recently been identified across the trust: patients who had been taken to the toilet would forget to ring the bell for assistance and would then fall. A poster had been designed to place in the patient toilets as a reminder. We checked all the toilets on ward 8 and did not see any of these posters in use. Minutes of the division A governance meeting in November 2013 stated that posters were to be put up in toilets to remind patients to ring for a nurse. However, it was not clear whether this information had been disseminated to all divisions and wards (ward 8 was in division C). The falls lead also told us that all falls classed as 'major' on Datix should be notified to them so that they could visit the ward and assess if any steps could be taken. We asked if they were aware of the fall that had occurred that week on ward 8 but they were not aware of this incident. In January 2014 there had been six falls; we saw on Datix that all of these had been classed as minor. Three staff were unable to tell us how these falls had been reviewed and whether any themes had been identified. Patients may be at risk of harm as themes from minor incidents were not reviewed and the reporting systems that were in place were not used in a timely way.

The ward was equipped with hoists, wheelchairs and other aids to enable the staff to care for patients. All the equipment that we saw was visibly clean and ready for use. The ward used stickers to indicate that an item had been cleaned and was ready for use. However, we spoke with two members of staff who told us that there was a shortage of the specialist chairs and that patients had to be timetabled to be able to sit in them. It was confirmed by the lead for physiotherapy that more chairs were on order and that the increase in the number of patients who had a high level of dependency was potentially having an impact on the availability of sufficient equipment.

Systems, processes and practices

The lead nurse and matron told us that the staffing levels on ward 8 had been reviewed using the 'safe staffing'

guidelines and this had resulted in a need for additional trained staff on a late and a night shift. These had been approved as permanent additions to the staffing levels. The number of staff on duty each day was displayed on the ward; we saw on the day of our inspection that the ward was one staff member down on the early shift. The lead nurse told us that, since the additional staff had been agreed, many staff had left due to concerns about the planned closure of the unit in the summer of 2014. Therefore, despite the recognised need for more staff, there were currently four full-time vacancies and thus a number of shifts were being covered by bank or agency staff. Efforts were made by the matron and lead nurse to request the same bank and agency staff to ensure consistency and safety. The need for bank or agency staff was reviewed on a six-week basis in a process called 'daily ward safe staffing' to enable bookings to be made in advance and to ensure that shifts were filled. We saw from the data for February 2014 that there were a number of shifts each week where bank or agency staff were required. The dependency of patients was recorded on the trust-wide 'real-time' system, which gave an overview of the trust status for staffing and enabled lead nurses to have a view if there were patients on a ward who needed close observation or one-to-one nursing. This enabled decisions to be made about prioritisation of need for bank and agency staff. We spoke with three staff about how they would report that the ward did not have sufficient staff. Two told us that they would report this on Datix, and one was not aware that this should be reported. Our review of Datix showed three occasions in December 2013 when a staffing shortage had been reported.

The trust had a system whereby matrons undertook quality rounds three times a week. Matrons walked around the ward areas and undertook a variety of checks. We observed that these checks included checks of care plans, medication, equipment and the environment. When we reviewed six quality rounds, it was evident that actions were documented if an area of non-compliance was found. The information was collected on an IT system known as 'survey monkey'. Staff told us that, if any concerns were found, they were dealt with at the time and were recorded on the survey monkey, and that information was shared with them following the review. While on the ward, we observed the medication round that was in progress. The nurses carrying out the round wore red tabards with a slogan that advised others that they were doing the medication round and were not to be disturbed. We saw that other staff adhered to this and medication rounds were completed without interruption.

Ward 8 was laid out as a long ward with four bays and six side rooms, with a nurses' station halfway down. Due to the layout, it was difficult to see the patients, apart from those in the two side rooms that were opposite the nurses' station. Toilets and bathrooms were designated for male and female patients and there were bathrooms for assisted baths and a wet room. The ward had a small room that could be used for more mobile patients to see their relatives away from the bays. At our last inspection, we raised a concern that a vanity unit in the wet room was wet and the wood had become damaged. During this visit we checked to see if this had been replaced but found that it had not. We spoke with the ward staff who confirmed that they had raised the issue. We also spoke with a member of the estates staff who explained that the unit had not been replaced as the ward was due to close. They told us that a unit was available and that this and the surrounding floor would now be replaced; they recognised that, despite plans for the ward to close, all facilities should be fit for purpose until that time. We also noted that the hand wash basin at the nurses' station did not comply with the current guidance for clinical hand wash basins. We saw that the area around the back of the sink was very wet and a pile of paper towels had been placed there to soak up the water. Staff told us that they had reported this and the estates team had tried to fix it, but they felt the water was from splashing as staff washed their hands due to the design of the sink.

Monitoring safety and responding to risk

All wards undertook monitoring of key areas of risk for patients; this included screening for methicillin-resistant Staphylococcus aureus (MRSA), hand hygiene compliance and documentation associated with invasive devices such as cannula (PVC) (a plastic needle inserted to give fluids or medication). A review of compliance showed 95% for hand hygiene in November and 81% in December 2013, with 100% for MRSA and PVC. Avoiding the unnecessary use of invasive devices and monitoring their use reduced patients' risk of harm and infection.

Patients who had a urinary catheter were monitored using a care bundle: this is a series of evidence-based elements

of care that should be reviewed daily, including the ongoing need for the catheter. We reviewed four patient records and saw that the bundle had been completed in all cases and it was clear why the catheter was still required.

We saw that the ward displayed the number of falls that had occurred in the current month. For February 2014, there had been four falls recorded in the seven days before our inspection. Staff we spoke with told us that they could request additional staff to provide one-to-one observation. On other occasions, a patient would be moved to where the nurses could see them. During our time on the ward, we saw that one patient who was confused and at risk of getting up from their chair had been positioned near the nurses' station; this meant that staff engaged with them, which appeared to reassure and settle them. An alarm was also in use; this was connected to the chair and to the patient's clothing by a small clasp. If the patient began to get up from their chair, the alarm would alert staff.

Anticipation and planning

Equipment including oxygen and a defibrillator was available on the ward in case of emergency. We saw that this was checked on a daily basis in line with the trust's policy. All equipment was present and ready for use.

All patients admitted to ward 8 had been transferred from wards at Wexham Park Hospital or other hospitals. There were specific criteria that had to be met by patients transferred to ward 8: they must be transferred for rehabilitation, not because of a delayed discharge for other reasons. These criteria ensured that patients were suitable for treatment on the ward and that their needs could be met. The planned length of stay for rehabilitation was for weeks, but it may be longer in some cases.

Heatherwood Hospital did not provide emergency care or treatment; at times this meant that patients who became unwell needed to be transferred to either Wexham Park Hospital or another local hospital. The lead nurse explained that the process for review and transfer of patients who were unwell would be assessed by the covering medical doctor. When a decision was made to transfer a patient, an ambulance would be ordered and medical staff at Wexham Park Hospital would be contacted so that they knew to expect the patient, who would be taken to the accident and emergency department in the first instance. The trust policy for patient transfers sets out guidelines for the transfer of patients due to a change in their condition. We spoke with three staff who were able to tell us what steps they would take if a patient became unwell and required transfer to a more acute ward.

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

Good

Using evidence-based guidance

The trust-wide National Institute for Health and Care Excellence (NICE) steering group met monthly and reviewed all guidance and responses. The specialty governance meeting minutes from February 2014 recorded that specialties would be invited to attend on a monthly rotation to discuss their NICE compliance.

Staff

We spoke with staff who were responsible for monitoring staff training. They told us that all staff had either annual or three-yearly training depending on the trust requirements. The ward matron would book all staff onto training courses, including other non-mandatory training. It was confirmed that all staff had attended dementia training. If staff did not turn up at a booked training session, an email was sent to the ward. The majority of sessions were attended, unless in case of sickness, and this was discussed and another session booked. New staff to the ward undertook a period of shadowing and being supervised. For instance, a new nurse would be assessed in administering medication by the practice development nurse before they could carry out medication rounds on their own. A member of staff told us that all staff had an annual appraisal; we saw from the trust data that 71% of staff had had one, with three months of the year left for appraisals to be completed for all staff.

Medical support and input to ward 8 was provided by the consultants for medicine and stroke care based at Wexham Park Hospital. The ward was covered 24/7 by two medical staff who attended daily to review patients. Outside normal hours, the ward was covered by the on-site medical staff, who could be accessed in the event of an emergency or if a patient's condition changed and required a medical review.

Good

Medical care (including older people's care)

Multidisciplinary working and support

Ward 8 is a rehabilitation ward that has a dedicated team of allied health professionals (AHPs), including physiotherapists and occupational therapists based on the ward. Each week day there was a meeting of the multidisciplinary team, including the nurses and medical staff. This ensured that all patients were discussed and their progress and plans for discharge reviewed and altered, depending on their needs and progress. Additionally, the nursing and AHP staff had a daily handover when changes from each shift were discussed. We reviewed the records of three patients who were due for discharge and saw that a comprehensive assessment their ability and needs had been documented by the occupational therapist.

There were systems to monitor the delivery of occupational therapy and physiotherapy care and treatment. Each patient was scored on arrival and discharge from the ward to assess the outcome of their rehabilitation. Staffing levels for occupational therapists had been a concern and had been raised on Datix when patients had not been able to receive their recognised level of 45 minutes of occupational therapy each day. We were told that a business case for more occupational therapy staff had been submitted for approval in order to secure sufficient staff to meet the patients' requirements.

One patient we spoke with was complimentary about the occupational therapist support that they had received. They had a home assessment that was attended by two staff who were "superb and encouraged me to do well". One member of staff we spoke with told us that plans for rehabilitation were begun before patients were transferred to ward 8 and that AHPs were involved in these; this ensured good communication with the nursing team.

The ward was supported by a pharmacist three days a week to provide advice and a review of medication. There were systems in place to ensure that medication was ordered via fax from Wexham Park Hospital. Wards were supported by an on-call pharmacist and had access to an emergency drug cupboard out of hours.

Are medical care services caring?

Good

Compassion, dignity and empathy

We spoke with five patients on ward 8, all of whom were very pleased with the care they had received and had no complaints. Some patients had memory loss as a result of a stroke and required more time to be able to speak; one patient told us that staff were "always patient with them and didn't mind having to repeat things". Patients spoke highly of staff, saying "the nurses are very good" and "doctors are super and very kind".

Involvement in care and decision making

Patients told us that they were allowed to move freely about the ward, if they were able to, and felt that staff involved them in making decisions about what was within their limitations. This promoted their independence on the road to recovery. Another patient described how the physiotherapist had given them a stick instead of a walking frame and had explained the reason why.

Trust and communication

We spoke with five patients who were complimentary about staff: they said that they worked well as a team and communication was good with both the patients and their families. One patient whose first language was not English told us that they were able to communicate with the doctors and nurses and understand what they were telling them. Another patient, who had recently transferred to ward 8 from Wexham Park Hospital, confirmed that their family had been communicated with throughout. Ward 8 had a large multidisciplinary team that described a close working relationship with regular meetings and communication regarding patients' needs, progress and discharge. We spoke with a physiotherapist who explained that there was a weekly meeting of the multidisciplinary team with the consultants and that there was a handover each day with the nursing staff. This ensured good communication and timely discharge of patients. Another member of staff we spoke with agreed that the different staff groups worked and communicated well together.

Emotional support

Relatives told us that staff were encouraging when patients lacked confidence in their recovery, and that their relative had made good progress towards being able to walk again.

Good

Medical care (including older people's care)

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patients were admitted for rehabilitation on ward 8 after being transferred from Wexham Park Hospital or another hospital. Staff told us that this would always be a planned admission following an assessment that the patient met set criteria. .

Vulnerable patients and capacity

Three patient records we reviewed contained assessments for dementia screening. Staff confirmed that they had attended dementia training and were aware that in some instances a 'best interest' meeting would be required if a patient were unable to make some decisions themselves. These meetings would have input from family, nursing staff and other members of the multidisciplinary team.

Leaving hospital

A pharmacist we spoke with on ward 8 felt confident that discharge medication was managed well: the majority of patients had a planned discharge and therefore any changes could be anticipated and the medication ordered in time for their actual discharge date. Where patients could not be discharged, home referrals to other care providers and assessments of need were documented. We observed a member of staff telephoning relatives and other organisations to update them and confirm forthcoming discharge arrangements.

Learning from experiences, concerns and complaints

All staff we spoke with were in agreement that patients and their families did not often make complaints. On the occasions when a complaint was made, we were told that this could be related to communication or expectations of progress being lower than anticipated. AHP staff said that they tried hard to explain the rehabilitation pathway and expectations to patients and their families by getting involved in discharge discussions at an early stage. Staff tried to resolve complaints as they arose and gave an example where issues with food had led to patients being able to choose an alternative from the staff canteen. We reviewed the number of complaints: there had been four formal complaints and four where patients and relatives had raised a concern via the Patients Advice and Liaison Service (PALS) in the last year.

Are medical care services well-led?

Good

Vision, strategy and risks

We were informed during our inspection that the rehabilitation services were being reviewed and that the provision of rehabilitation was to move to more community-based services linked to the Clinical Commissioning Group, with some beds provided at Wexham Park Hospital. These changes were due to come into effect in the summer of 2014. Some staff had already made a decision to leave the ward and this had resulted in four full-time vacancies that were being covered by bank and agency staff.

Governance arrangements

Wards and departments at Heatherwood Hospital followed the governance arrangements for the relevant trust division with which each one was linked. Primary responsibility for these areas lay with the lead nurses for each 'care group' within a division: for instance, ward 8 was part of division C. The lead nurses visited their areas of responsibility at least once a week to provide support to the matrons and to hear any concerns. The lead nurse attended the specialty governance meetings, which were chaired by a clinician. These meetings reviewed all incidents, including those identified as serious. Meetings also provided an opportunity to audit activity, with key aspects being fed into the divisional governance and trust-wide governance meetings.

Divisional governance meetings received and reviewed information on incidents. Evidence indicated that major falls and incidents were discussed to determine learning. The numbers of falls and the level of harm as a result were reviewed at the divisional level, with further details of incident data being available at the specialty meetings that report to the divisional governance meetings. The minutes from the specialty governance meeting held in February 2014 recorded that a falls audit was being undertaken

across the trust and the results were awaited. Concerns about the levels of staff on ward 8 were also discussed, as was the fact that approval had been given to recruit for the vacant positions.

Leadership and culture

Staff we spoke with appeared to work as a team, for example by ensuring that they supported all patients at lunchtime and did not rush them. We saw the AHP staff talking to patients and assisting the nursing staff if required, especially with observing patients at risk of falling who were prone to getting up from their chairs. The ward matron was new in post and was being supported by the lead nurse for the division; the matron told us that they were always able to access the lead nurse if required. One member of staff said that the policy for staff to be 'bare below the elbows' was enforced and that those not adhering to the rule were challenged.

Patient experiences, staff involvement and engagement

Patient views and experiences were reported via the specialty governance meetings, where the 'Friends and Family' results were recorded. Information about the ward was displayed so that it was visible to staff, patients and visitors, which helped to provide a culture of openness. The displays included information on the results of audits of hand hygiene as well as the ward cleaning schedule and the results of cleaning audits.

Good

Surgery

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

Information about the service

Heatherwood Hospital provides surgical services for elective orthopaedics and general surgery, which includes a pre-operative assessment clinic, short stay surgery, day surgery and operating theatres.

Summary of findings

Patients received safe and effective care. Staff were aware of how and when to report incidents, and they confirmed that they had feedback on these and learnt lessons to improve patient care. Care was delivered in line with national standards and evidence-based practice. Staff were trained appropriately to deliver care to meet patients' needs. Multidisciplinary staff working was effective in achieving patient outcomes and planning discharge from hospital. Patients were positive about all aspects of the surgical pathway and all groups of staff involved in their care and treatment. Monitoring was undertaken and action plans were in place to address areas of non-compliance.

Good

Surgery

Are surgery services safe?

Requires improvement

Safety and performance

We reviewed 18 comment cards completed by patients in the weeks prior to our inspection. All were complimentary about ward 4, particularly that the environment was clean and staff appeared professional, diligent and expert in their roles, which gave confidence to patients that they were safe.

A review of audits for hand hygiene compliance showed rates between 89% and 100%. Audits of patients at risk of a venous thromboembolism demonstrated that more than 96% of those requiring assessment were assessed within 24 hours of admission.

In line with World Health Organisation (WHO) recommendations, the trust monitored patient safety using the WHO surgical safety checklist. This has been shown to reduce harm during surgical procedures and consists of a number of checks before, during and after surgery. The trust had undertaken an audit of compliance with the WHO checklist in November 2013. Findings were that not all documentation was completed as required; at times, completing the checklist was seen as a 'tick box exercise' rather than an activity in which all staff present in the operating theatre should be involved. The lack of documentation and engagement with the checklist may result in surgical procedures not conforming to all the criteria and in patients being placed at risk of harm. An action plan to address the concerns highlighted by the audit was being put in place.

For patients who required a urinary catheter, their care was reviewed daily using a recognised tool called a 'care bundle'. This included key areas of assessment of adherence to national guidelines to ensure that the catheter was inserted and managed and the requirement for its ongoing use reviewed. Medical staff we spoke with told us that those patients who required a catheter due to their surgery would have it removed 24 hours after their operation. We saw that this was documented for one patient whose records we reviewed.

All wards and departments we visited were seen to be clean. While the exterior of the buildings was old and in some need of attention, the clinical areas were satisfactory. Alcohol hand disinfectant was available at the entrance to wards and at the bedside, and staff were seen to use it between patient contacts. Ward cleaning schedules were displayed along with the results of the cleaning and environment audits; the latest results were 100% for nursing staff and 95% for domestic staff areas of responsibility. .

Learning and improvement

We spoke with six staff, all of whom were aware of the incident-reporting system known as Datix. There were few incidents reported from the ward but these would be discussed within the team to learn and improve where required. Medical staff told us that they were kept informed of learning from incidents and showed us emails where such learning had been circulated.

Systems, processes and practices

We reviewed three sets of patient records and noted that all risk assessments had been undertaken, including assessments for falls, dementia screening and manual handling. These were completed in the pre-operative assessment clinic so that care plans could be put in place at the time of admission; this ensured that patients' needs were met and their safety maintained.

All patients undergoing surgery were screened for MRSA prior to their surgery. Where the results were not available for one patient, staff told us how they had explained that the patient could not be first on the operating list and a nasal spray was prescribed as a precautionary measure.

The trust had a protocol for pre-operative assessment that was followed in order to identify which patients were suitable for surgery at Heatherwood Hospital site and which needed an anaesthetic opinion prior to their surgery. This served as a second check, as the surgeon who booked the patient made an initial assessment as to their suitability for surgery at Heatherwood. The pack referenced National Institute for Health and Care Excellence (NICE) guidelines for pre-operative assessment and on which tests should be given to which patients.

On the short stay ward, there were up to 10 patients staying overnight with three staff on duty. This would be a mix of trained nurses and healthcare assistants. Staffing on ward 4

was described as good with a low turnover and infrequent use of bank or agency staff. The number of staff on duty for each shift over 24 hours was displayed on the ward and indicated any shortages.

Four nursing, medical and AHP staff told us that they were supported by their manager and had an annual appraisal and supervision sessions. All staff felt that they were able to attend the required mandatory training, either annually or every three years, depending on the topic. Staff were able to book themselves on training and this was monitored by the matron to ensure that all staff members were compliant with requirements.

Monitoring safety and responding to risk

All wards undertook monitoring of key areas of risk for patients; this included MRSA screening and monitoring of documentation associated with invasive devices such as cannula (a plastic needle inserted to give fluids or medication). A review of compliance was 80% to 100% in the three months prior to our inspection.

One patient who was due to be a day patient was kept in overnight to monitor their blood pressure. They told us that they were given a full explanation of the reason. This gave them confidence that they were being closely monitored and that any risk would be identified.

During our visit, a patient had become unwell, which meant that they needed to be transferred to Wexham Park Hospital. We observed that the nursing and medical staff worked in a calm and supportive way to ensure that the patient was monitored closely throughout and they sought a review from an anaesthetist. Discussions were held with staff at Wexham Park Hospital to hand over the details of the patient's condition and arrangements were made to inform the family and book the required paramedic transport with an urgent request. Our observation was that the situation was dealt with in a professional manner with no distress or anxiety to the sick patient or to others in the ward.

Anticipation and planning

All patients undergoing elective surgery attended the pre-operative assessment clinic, which was a nurse-led clinic. Any concerns that may have impacted on their recovery or placed them at risk from the procedure or anaesthetic would have been identified and reviewed at this stage. In some cases, this may mean that a patient needed to have their surgery at Wexham Park in case of complications or if their condition required closer monitoring after surgery. Staff we spoke with were clear that no risk would be taken if there was any concern that a patient was not suitable to have their surgery at Heatherwood Hospital. Arrangements were in place for an anaesthetist in the pre-operative assessment clinic to review patients. On other days, if an anaesthetic review was required, then the anaesthetist on site would review patients.

As Heatherwood Hospital did not provide emergency care or treatment, on occasion there was a need to transfer patients to another ward within the trust or to other healthcare provider. The trust had a policy for transfer of patients between areas that used the ACCEPT principles: these took into account assessment, control, communication, evaluation, preparation and transportation. Responsibilities of staff involved in the assessment and onward transfer were identified along with guidelines for ensuring that the correct mode of transport was booked and the patient and their relatives informed of decisions. Our observation of the transfer of a sick patient was in line with the trust's policy.

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

Good

Using evidence-based guidance

Patients undergoing surgery on major joints, such as hip and knee replacement, were placed on the enhanced recovery programme. This was a programme that began prior to surgery and aimed to speed up recovery and discharge after surgery. The programme focused on making sure that patients were active participants in their own recovery process. It also aimed to ensure that patients always received evidence-based care at the right time.

We saw that there was a clear protocol as to which patients were operated on at Heatherwood Hospital, and which needed an anaesthetic opinion prior to surgery. This served as a second checking point as the surgeon who panned the operation list made an initial assessment as to the patient's suitability. The protocol for pre-operative assessment referenced NICE guidelines about pre-operative assessment and on which tests should be given to which patients.

Good

Surgery

Division A participated in the trust's NICE Steering Group and was currently conducting an urgent review of its compliance with guidance to identify applicability and, where relevant, compliance. In November 2013, the division assessed that 31 guidelines had been identified as either having been reviewed and the trust had not implemented them within three months, or trust status in relation to the guideline was unknown three months after issue. The November 2013 divisional governance report noted that 66 clinical guidelines were in need of updating to ensure effective management of risk within the division. This work was being led by the medical director.

There were trust guidelines for the use of antibiotics prior to surgery that identified the appropriate antibiotics for specific types of surgery, for example orthopaedic joint replacement and laparoscopic procedures and for those patients who were identified as carriers of methicillin-resistant Staphylococcus aureus (MRSA). The guidelines included information on which antibiotics to be used in the event of an infection. Adherence to guidelines ensured that the risk of infection was reduced and that, in the event of an infection, appropriate antibiotics would be prescribed. Medical staff we spoke with ensured that they carried a pocket-size booklet of the guidelines so they could access them at any time.

Performance, monitoring and improvement of outcomes

A review of patients' outcome data demonstrated that there was low mortality data for elective hip and knee replacements. We reviewed the records of two patients who had undergone surgery and saw that the WHO checklist had been completed at all stages for both patients. The trust participated in national infection surveillance for hip replacements and we observed that the relevant data had been collected for the patients we reviewed. Monitoring of surgery for effectiveness of types of surgery was also reviewed through participation in the National Joint Registry, which required information on the type of joint used to be recorded and data submitted centrally for collation and evaluation.

The trust had a system of quality rounds undertaken by the matrons three times a week. Matrons walked around the ward areas and undertook a variety of checks. We saw that these checks included checks of care plans, medication, equipment and the environment. The information was collected on an IT system known as 'survey monkey'. Staff told us that, if any concerns were found, they were dealt with at the time and were recorded on the survey monkey, and that information was shared with them following the review.

Staff

Medical staff support and input to ward 4 and short stay surgery was from the consultants and medical staff based at the hospital during the day. There was 24/7 cover from the on-site medical staff, who could be accessed in the event of an emergency or if a patient's condition changed and required a medical review. If required, the anaesthetists could also be called upon during the day.

Equipment

There was a range of equipment on the wards and the occupational therapists had access to equipment in an on-site store. On our previous visit to ward 4, we had noted that storage of some equipment was in an open area accessible from the bathroom. On this visit we saw that a wall had been installed and that the equipment was now in a cupboard and protected from exposure to contamination. Wards appeared to have sufficient equipment to support patients with their recovery. However, the availability of occupational therapy equipment required for discharge was dependant on the area in which the patient lived: some external organisations had a greater range and stock than others. Equipment was seen to be visibly clean and ready for use with commodes dismantled and stickers used to indicate that items had been cleaned.

Emergency equipment in the resuscitation trolley was checked in accordance with trust policy to ensure that it was ready for use in an emergency.

Multidisciplinary working and support

Staff we spoke with told us that there was a good multidisciplinary team (MDT) with physiotherapists and occupational therapists based on the wards. There was daily communication between the MDT staff to ensure that patients were provided with the support and treatment they required and to ensure timely discharge planning. Patient recovery was supported by specific care pathways depending on their surgery; this ensured that mobilisation and discharge were planned with input from AHPs in a coordinated way.

Are surgery services caring?

Good

Surgery

Good

Good

Compassion, dignity and empathy

On ward 4, patients described staff as respectful and caring, putting their mind at rest over any questions they had about their surgery.

Two patients we spoke with were satisfied that staff reviewed them regularly to see if they were in pain and then ensured that medication was given to relieve this. Patients were checked a number of times a day to ensure that they had drinks and were pain-free; these checks were documented in the four records we looked at.

Involvement in care and decision making

Patients we spoke with in all wards conveyed their view that all staff were very caring. One patient we spoke with who had undergone recent knee replacement surgery had previously been a nurse at Wexham Park and was very happy with the care they had received at Heatherwood, reporting no issues with the environment, food or pain management. Another patient recovering from a hip replacement was pleased with their progress and the care and attention that the whole team had given them. They had received timely and clear information at all stages, from pre-admission to planning for their discharge home.

Trust and communication

Patients we spoke with on ward 4 were pleased with the amount of information they received prior to their surgery. One patient expressed how the expertise of the clinical staff was matched by their warmth and consideration for patients and for the other staff they worked with.

Emotional support

Patients told us that staff were very attentive to their needs, with one patient describing how a nurse took the time to sit with them as they were very anxious about their surgery. Another patient, who had never been in hospital before, commented on how attentive and kind the staff were and that they made the time to talk to them.

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

Meeting people's needs

Patients' needs were assessed, and then care was planned and delivered in line with this assessment. A review of four patients' records demonstrated that the process in the pre-operative assessment clinic was thorough, with risk assessments being completed alongside identification of other needs.

Toilets and bathrooms were designated for male or female use to ensure privacy. The day surgery unit had no single-sex areas, but large individual bed areas with curtains to provide privacy seemed adequate. In the theatre unit, they had recently put up a curtain to provide more privacy in the recovery area: this was a main thoroughfare and without the curtain the patients would have no privacy whatsoever. In the main area of ward 4, a poster that demonstrated how to wear a dignity gown prior to surgery was easily visible.

Vulnerable patients and capacity

The patient records we reviewed included completed dementia screening assessments. As patients attended a pre-operative assessment clinic, any issues relating to consent would be identified and appropriate arrangements for consent made.

Access to services

Patients undergoing elective surgical procedures were subject to standard waiting times from referral to surgery. Records showed timescales of approximately a month from pre-operative assessment to admission.

Leaving hospital

The ward had pharmacy support for the review of discharge medication. At times when the pharmacist was not available on the short stay unit, the nursing staff were able to provide pre-packaged medication for patients to take home. In the three records we reviewed, discharge plans were documented and included information on who would be available to provide support to the patient in the first 24 hours after their discharge.

Learning from experiences, concerns and complaints

All the staff we spoke with said that there were very few complaints from patients. On the occasions when a

complaint was made, staff always tried to resolve things quickly. Complaints were discussed at the specialty governance meetings. Feedback from the 'Friends and Family' surveys was also positive and displayed on ward 4. We reviewed complaints for ward 4, day surgery and theatres, and saw that there had been six, one and three respectively in the last year. There were three informal complaints and concerns raised with the Patients Advice and Liaison Service (PALS) for ward 4 and two for short stay surgery.

Are surgery services well-led?

Good

Vision, strategy and risks

The trust's strategy and vision for Heatherwood Hospital was focused on the ongoing provision of mainly elective orthopaedic surgery on the site. This would be delivered through redevelopment of the site.

Governance arrangements

Wards and departments at Heatherwood Hospital followed the governance arrangements for the relevant trust division with which each one was linked. Primary responsibility for these areas rested with the lead nurses for each 'care group' within a division: for instance, ward 4 was part of division A. The lead nurses visited their areas of responsibility at least once a week to provide support to the matrons and to hear any concerns. The lead nurse attended the specialty governance meetings, which were chaired by a clinician and were reported as being well attended by the consultant staff. These meetings reviewed all incidents and audited activity, with key aspects being fed into the divisional governance and trust-wide governance meetings. Divisional governance meetings received and reviewed information on incidents and there was evidence that major falls and incidents were discussed to determine whether there were lessons to be learnt. The numbers of falls and the level of harm as a result were reviewed at the divisional level, with further details of incident data being available at the specialty meetings that report to the divisional governance meetings.

Leadership and culture

Nursing teams were well led, with a clear view of their role and awareness of where they could improve. Two staff we spoke with told us that the ward matron ran the ward well and they were happy with their work in the wards. The ward was well organised with prominent displays of audits and metrics along with information for patients. There were two doctors based on the ward who confirmed that the team all worked well together and that they would discuss any issues within the MDT. The ward team was stable with a good level of staff retention and only one vacancy, which was due to a recent retirement. All staff we met and spoke with were open and eager to speak to us about their role and the performance of the ward.

Patient experiences, staff involvement and engagement

Feedback from patients was gathered using the 'Friends and Family' test and compliments that were displayed in the wards. All staff we spoke with felt that they were part of a local team but were kept in touch with what was going on in the trust as a whole via the intranet and regular emails from senior management. There was a feeling of localism as Heatherwood was a smaller site with a lower turnover of staff.

Learning, improvement, innovation and sustainability

The local governance system encouraged reporting of incidents, and discussion and feedback mechanisms were in place. We were advised that while other services on the Heatherwood site were due to close, the provision of elective surgery was to continue with site redevelopment. The surgical services participated in a range of national audits that would lead to improvements in patient care and treatment, such as the National Joint Registry and Surgical Site Infection Surveillance programme.

Requires improvement

Outpatients

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

Information about the service

Heatherwood Hospital is located in Ascot, Berkshire. It runs nine outpatient clinics a week, which include ear, nose and throat (ENT), orthopaedics, paediatrics and radiology.

Summary of findings

We found that some improvements were required to keep outpatients services safe for people at Heatherwood Hospital. These included better infection control and systems to ensure that people received treatment in a timely way. Improvements were required to ensure that the outpatients service was effective, including better performance in arranging appointments in line with the trust's own policies.

We found that the hospital was good at caring for people on a one-to-one basis. Most front-line staff were respectful and considerate.

We found that the trust was not responsive and we have rated this area as 'inadequate'. Insufficient work had been done to improve the appointment booking system, waiting times and the cancellation of clinics.

Improvements were required to ensure that the service was well led. At a local level there was good leadership, but this needed to be improved at senior manager level.

Requires improvement

Outpatients

Are outpatients services safe?

Requires improvement

Safety and performance

Although our analysis of the National Reporting and Learning System (NRLS) data, the NHS's patient safety system for reporting incidents, showed that the trust was under-reporting incidents, we saw from divisional governance reports from quarters two and three of 2013/14 that incident reporting had been gradually increasing at the trust. This was without any corresponding increase in high-impact incidents. According to the NRLS, high levels of reporting combined with low incidence of high-impact incidents is suggestive of a healthy reporting culture. Staff told us that they were encouraged to report incidents and near misses. However, we were also told by a number of staff that the trust did not always provide feedback to them after the matter had been investigated.

One nurse told us that they had not received any training in incident reporting.

Systems, processes and practices

We looked at the trust's systems for the prevention and control of infection at Heatherwood Hospital. The trust's monthly hand hygiene audits showed that the OPD and radiology department in Heatherwood Hospital scored 100% compliance in October, November and December 2013. However, in respect of the infection control and hygiene audit for the same months, the radiology department scored only 89%. The OPD scored 100%. When we visited the radiology department, we saw prominent signage to advise people of the importance of good hand hygiene and to remind them to use the hand gel dispensers. Staff told us that the display board had been put up only the week before our inspection, and when we tried to use the hand gels we found that the dispensers were empty. We also observed no staff using hand gels to sanitise their hands at any time during our inspection of the outpatients services at Heatherwood Hospital.

In one area we visited we saw that the hospital was still using fabric curtains for privacy and dignity. We were told that they were changed every six months, or sooner if they became contaminated, and that the trust was moving towards the full use of disposable curtains. They were awaiting delivery of the disposable curtains. The curtains we examined appeared clean and free from splashes.

There was quite a large leak from the glass roof in the OPD waiting area. This area had been sectioned off but was still a slip hazard.

Monitoring safety and responding to risk

We found from our interviews with staff and with the divisional management teams that there was a clear understanding and awareness of the risks that affected the safe operation of the OPD service. These risks were discussed in the divisional governance reports we saw for quarters two and three of 2013/14 and on the trust's risk register. These showed that areas were identified for action and progress was monitored. We noted that the trust had also established an OPD programme board to steer the wide range of improvement activities in progress.

We saw that resuscitation trolleys and emergency medicines had been checked daily and were properly stored to ensure that they were ready to use in the event of an emergency. However, we found that drugs were stored in the clean utility area. The keys to the medicines cupboard were stored elsewhere, but all staff could access these. The protocol for the storage of the keys should be reviewed, so that only those staff who need to access medicines are able to do so.

We found that the trust had good links with social services in respect of the reporting of safeguarding incidents. Staff we spoke with demonstrated that they had received training in safeguarding and spoke about the processes to follow to ensure that concerns about the welfare of patients were escalated in line with the trust's policy.

Anticipation and planning

We found that staff were up to date with training, or had training booked. Training days were protected and run via academic half days once a month. Part of this training included level 3 safeguarding training. Staff we spoke with said that they had received this training and discussed the actions they would take to raise and escalate a matter if they suspected that abuse had taken place.

Are outpatients services effective?

(for example, treatment is effective)

Requires improvement

Outpatients

Not sufficient evidence to rate

Staff, equipment and facilities

Equipment was found to be well maintained throughout the department. We found that clinical areas underwent a start-of-day check to ensure that they were equipped with essential kit, and that this was serviced and in a good state of repair.

Multidisciplinary working and support

Staff told us that they felt isolated from the main hospital but said that the teams at Heatherwood Hospital were very close and supportive of each other.

Are outpatients services caring?

Good

Compassion, dignity and empathy

We observed good care taking place on a one-to-one basis. We saw good communication between a clinician and a patient about how to take medicines. The interactions between nursing staff and patients were friendly and respectful. We saw that one room did not have any privacy curtains but were told that these were on order. Instead, staff were using a screen in an attempt to ensure privacy and dignity, but this was not very effective.

Involvement in care and decision making

We received mixed feedback from people using the service at the time of our inspection.

One patient described a doctor as being "rude and uncaring" in the way they had told them that they were not prepared to operate any more. They said they were then referred to another surgeon, whom they described as "kind, caring and explained everything". Another patient said that staff were very caring.

Trust and communication

We found good examples of verbal communication with patients during the consultations we observed. Staff put people at ease and involved them in decisions about their care. Information was provided in a way that was relevant to the patient and their needs.

Emotional support

One consultant we spoke with said that clinics at Heatherwood were overbooked and this made it hard to keep to time and provide the support that people required. Medical records staff said they worked closely with patients and, as Heatherwood Hospital is small, they get to know their patients and their needs well.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Inadequate

Meeting people's needs

People were concerned about the booking system, late appointments and car parking. Whilst we found that the trust was taking steps to try to address these issues, we had major concerns about the responsiveness of the trust to meet the needs of patients at this time. Examples of these concerns are outlined below.

Staff and patients told us that clinics ran late for a number of reasons, which included doctors not starting on time and appointments being double, or triple, booked. We heard from a nurse, a matron and a consultant at Heatherwood Hospital about the late running of clinics. Comments included that staff found it frustrating that clinics ran late, which made patients get upset. Staff said that late running was because of the number of appointments that are booked in a day. The consultant told us that clinics are overbooked and that this made it difficult to provide the care required in the time allocated. One patient said that they had waited two hours; they could not understand the reason for the delay and no explanation had been provided. Furthermore, we observed that receptionists and staff were in close proximity to the patients who were waiting but did not keep patients up to date or communicate particularly well with them.

The number of cancellations of appointments was also of concern. In the third quarter of 2013/14, the trust cancelled 1,221, 1,063 and 1,133 appointments for October, November and December respectively. Of these cancellations, 461, 644 and 707 appointments were cancelled for 'avoidable reasons'. Of the total number of appointments cancelled in that quarter, 559, 742 and 989 were cancelled with less than six weeks' notice, which was a breach of the trust's access policy.

This had been placed on the corporate risk register and performance was being monitored at divisional governance meetings. As a result an independent specialist contractor was reviewing the booking system and the time allocated for clinics.

Vulnerable patients and capacity

Information was available for people who did not speak English as a first language. There was a very good and responsive translation service available and written information signposted people to obtain it in a different language. However, there was no information available in a format for people with a learning disability (LD). There were no LD qualified nurses available in any clinic, but staff did say that they had received some LD training. The lead nurse was the lead for LD, but they too had no LD qualification and were based at Wexham Park Hospital. We were told that the trust was trying to recruit a suitably LD-qualified person. There was a paediatric outreach clinic held at Heatherwood Hospital but we found that there was no paediatric-trained nurse present at this clinic.

When booking first appointments, the booking office was made aware if a person required to use the patient transport service (PTS) or if they required an interpreter. These would then be arranged. However, there was no facility to identify if the patient had an LD, which meant that this would not be picked up until the patient arrived for their appointment and no support would have been put in place.

We found that the late running of clinics meant that some patients missed their PTS time slots to be taken home and some had a long wait for the next PTS vehicle. Furthermore, when appointments were cancelled at short notice, the trust was liable for the cost of the transport or an interpreter.

Access to services

The trust had an access policy that set out the booking system, arrangements for clinic referrals and cancellations, and equitable access to its OPD services. However, we found that the numbers of cancellations regularly put the trust in breach of the policy.

One patient told us that they had waited eight months for an OPD appointment. They said they had also been waiting on the day of the appointment for two hours and they had been to the reception desk on four occasions to enquire about the reason for the wait. They said that they lived next door to St Mark's Hospital (another of the trust's OPD sites) but had to travel to Heatherwood, which they felt was unreasonable.

Leaving hospital

People using the OPD services were not admitted to the hospital and left following their OPD appointment. We found that doctors did not always provide patients with a copy of the letter of their findings, despite the trust issuing a directive to doctors in October 2013 that this must be done. Staff told us that it "depended on the consultant" whether or not they provided the patient with a letter.

Learning from experiences, concerns and complaints

We saw that the trust was regularly monitoring the areas of risk at divisional governance and board levels in response to the complaints and appointments issues. These issues were on the risk register and the trust had contracted a specialist to review the booking and appointments systems. All staff we spoke with were aware of the project and they said that some improvements had been made, but that there was still a high number of appointment cancellations and late running of clinics taking place. The latest divisional governance reports showed that six out of nine formal complaints about the service were overdue a formal response.

Are outpatients services well-led?

Requires improvement

Vision, strategy and risks

Staff we spoke with were generally unsure about the trust's vision and strategy. One member of staff told us that teams "used to know what the trust stood for" and what its vision was, but not anymore. They said that this had been discussed at a recent team meeting. However, they told us that there had been no action taken, or feedback given, following this meeting. In respect of strategy, we found that staff felt that the trust was focused on the move to merge with another regional trust later in the year. This had caused staff to lose strategic focus and, to some extent, identity and pride in the trust they worked for. One member of staff at Heatherwood Hospital said that staff were confused about the merger and what the consequences of this would be for staff and patients.

Requires improvement

Outpatients

Within OPD, we found that all staff we spoke with, from those in front-line positions to divisional managers, were clear about the risks and areas that required improvement, the main one being the OPD appointments system. All staff were knowledgeable about the areas for development. We found a clear reporting process for risk and that risks were regularly reviewed at team, divisional and board levels. The risk register was also completed and reviewed.

The OPD programme board had been established to steer the wider range of improvement activities in progress within the trust's outpatient services. This board had met only twice and minutes showed that progress was being monitored, although it was too early to make a judgement on the effectiveness of the board.

Governance arrangements

There was a clear governance structure in place. Staff we spoke with could tell us about how incidents were recorded and escalated and how the flow of information operated from 'board to ward' and vice versa, although one nurse said that they had not received any incident-reporting training. However, another nurse told us that if they recorded a matter on Datix, the trust's incident-reporting system, they did not always get feedback on how the matter had been resolved.

All areas we visited displayed governance structure charts and pathways for departmental business reporting and the escalation of concerns, such as safeguarding matters. We noted that some of this information was dated just one or two days before our inspection visit, so we were unable to confirm whether this information had been available any earlier than the date on the chart. However, staff we spoke with were relatively well informed about the governance arrangements, particularly within their own division.

Leadership and culture

Staff we spoke with could tell us who the managers were within the division, their roles and where they were in the management structure of the division. Staff said that they felt supported by colleagues and managers within their teams. Staff had a generally good opinion of managers at divisional level. Staff at Heatherwood Hospital said that they felt isolated to some extent but that they worked in a very close and supportive team locally. One member of staff said they were not aware of the whistleblowing policy and how to properly raise concerns if they suspected poor practice. They said that in such an event they would probably discuss the issue with their line manager in the first instance.

In respect of the trust board, front-line staff said they did not feel supported. They said that the only member of the executive team they saw with any regularity was the chief executive. They said she visited Heatherwood Hospital often, and even had an office there. However, we did not find any members of nursing staff who recalled meeting any other board director, including the director of nursing, who had been in post since June 2013.

Patient experiences, staff involvement and engagement

Patient feedback was obtained in each clinic and sent to the lead nurse, who collated the responses. We also looked at patient feedback returns that had been left in the OPDs we visited. Feedback was generally positive about the care they had received, but concerns were recorded about waiting times.

Staff told us that the various methods of communication in the trust included messages on the shared intranet matrons' meetings, team briefs and team meetings. Good teamwork and involvement seemed to exist within local teams and was facilitated by their own matrons and care group managers. One member of staff referred detrimentally to the senior management as 'Big Brother'. Apart from the chief executive, no senior board member made a point of engaging with front-line staff.

Learning, improvement, innovation and sustainability

The trust was attempting to address various issues affecting OPD in terms of clinic waiting times, and proposed a move to seven-day working and 12-hour shifts. This was being monitored at various levels within the trust and the OPD programme board had been established to oversee and implement the changes. However, we were advised by the director of quality improvement that clinical engagement on the matter was proving difficult and that 'cultural' changes were needed to improve behaviours, increase clinic times and see more patients per session. They were satisfied that more patients were now being seen per session and that they had better tools available to

plan work. However, the latest figures in terms of the full template renegotiation was under 10%, which showed that the trust still had much work to do to implement the improvements needed.

We saw some areas locally where improvements were taking place: for example, the MRI service was available at weekends at Heatherwood Hospital. At an OPD-wide level, it is difficult to assess sustainability given the amount of work that still needs to be done and the fact that there appears to be a focus on the trust's future merger.