Buckinghamshire Healthcare NHS Trust

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because Buckinghamshire Healthcare NHS Trust had been flagged as a potential risk on the Care Quality Commission's (CQC) intelligent monitoring system. The trust was one of 11 trusts placed into special measures in July 2013 after Sir Bruce Keogh's review into hospitals with higher than average mortality rates. There were concerns about the care emergency patients and the care patients whose condition may deteriorate, staffing levels particular of senior staff at night and the weekends, patients' experiences of care and that the board was too reliant on reassurance rather than explicit assurance about care and safety.

We inspected Stoke Mandeville Hospital, Wycombe Hospital and Amersham Hospital. We did not inspect the Minor illness and Injury Unit at Wycombe Hospital as this is run by Buckinghamshire Urgent Care Service. The announced inspection took place between 19 and 21 March 2014, and unannounced inspection visits took place between 7pm and 11pm on Friday 28 March and between 6pm and 10pm on Saturday 29 March 2014.

Overall, this trust was found to require improvement, although we rated it good in terms of providing effective care and having caring staff.

Key findings related to the following:

Overview

- We recognised that the trust had worked hard and had made significant progress since entering special measures in July 2013. Most of the trust's 25 point Keogh Mortality Review action plan was completed and the trust had developed a quality improvement strategy for continuous improvement. New services had been introduced and reorganised to manage the flow of patients through the hospital and improve the emergency care of patients. Governance arrangements were comprehensive and quality and performance were monitored for each service and displayed in ward areas for patients to see. The trust had engaged with the public to improve services.
- The trust had identified significant risks around staffing levels, discharge planning and managing patient flow, and these still remained despite service change. Services were recognised as being on a pivot edge and there were concerns that any sudden significant increase in demand could make the A&E and emergency care pathway unsafe. The trust needed to continue to actively manage demand, develop service strategies, and engage effectively with partners, staff, patients and the public to sustain and develop effective services.
- Staff were very positive about working for the trust. They said that the trust was more "open" and "positive" and real differences had been made in a relatively short time to improve quality and the patient experience.

Key Findings

- Special measures was designed to provide intensive support to challenged trusts: The trust had had external reviews of the leadership team, support from the Emergency Care Intensive Support Team (ECIST) and was partnered with Salford Royal NHS Foundation Trust to share their processes around staff engagement, collaborative learning and continuous improvement. The trust had described this relationship as extremely positive.
- The trust leadership was rated as 'Requires improvement'. Many of the leadership team were fairly new in post and they acknowledged that the trust was at the beginning of a journey of improvement. The trust had changed and improved its governance structures to have explicit assurance about care and safety. They had made credible and significant progress against their action plan under special measures and had developed a quality improvement strategy to reduce mortality, reduce harms including looking at care and management of the patients whose condition may deteriorate and to improve the patient experience. The leadership team were proactive in taking action on identified risks, and open and transparent about challenges, successes and failures.
- We rated the trust services in critical care, maternity and family planning, children's care and the National

Summary of findings

Spinal Injury Centre as 'good'. A&E, Medical (including older people's) care, surgery, end of life care and outpatient services were rated as 'requires improvement'.

- Overall, we found that staff were caring and compassionate and treated patients with dignity and respect, although staff shortages and busy ward areas meant the patients care needs were not always met. The trust's number of patients that would recommend the hospital to friends and family had increased in inpatient wards but was below the England average in some ward areas and A&E.
- The trust had worked to improve emergency care and had improved its mortality rates. Patients whose condition might deteriorate were identified and escalated appropriately. All patient deaths were reviewed by senior clinicians to identify where standards of care needed to improve. Learning was shared on themes around suboptimal care and potentially avoidable or preventable deaths. In March 2014, the trust mortality rates were within the expected range.
- Staff followed infection control practices and infection rates in the hospital were similar to those of other trusts.
- Nursing staffing levels were assessed using the national Safer Nursing Care Tool and minimum staffing levels had been set. The trust had staffed its ward areas according to a national recommendation of one nurse to eight patients and there were currently 90 nurse vacancies some additional nurses had been recruited. Wards and patient areas were staffed appropriately but there was a heavy reliance on bank and agency staff to fill vacancies, and the absence of skilled and experienced nurses was affecting the delivery and continuity of patient care. Staffing levels were checked for each shift and concerns were escalated when staffing fell below this level or for the acuity on the wards. Some wards considered that staffing levels were not appropriate and the trust is working to support staff to improve their understanding of the Safer Nursing Care Tool. The trust strategy was to invest in staffing levels that represented one nurse to six patients.
- The trust had employed an additional 16 doctors and had plans to employ more consultants in emergency care (four more A&E consultants and three consultants in acute medicine). Current arrangements were moving towards seven seven-day services but there was still a concern about the presence of senior medical staff out of hours and at weekends, and the number of medical patients that a junior doctor had to cover out of hours. The trust were developing plans to increase specialist to support to emergency care and have consultants in medicine and surgery covering admissions for the day.
- The trust had opened a new acute medical admissions unit, surgical assessment unit and clinical decision unit for short stay patients in November 2013, to improve the flow of emergency patients through the hospital and speed their assessment, treatment and discharge. During our inspection however, we found the hospital to be busy and under pressure. There had also been a reduction in the number of hospital beds due to Norovirus. The trust described this as an exceptional circumstance as there were restrictions on one quarter of medical beds over a 10 day period in March 2014. Capacity in A&E, on the shorty stay wards and in the hospital was severely reduced and patients who required longer stay were in wards designated for short stay.
- The trust was struggling to meet the 95% target for the admission, discharge or transfer of patients within four hours of attendance. There was a local agreement for the 4-hour target reported by the trust to include data from the minor injury and illness unit at Wycombe Hospital, which was managed by a different provider. This had significantly improved the trust performance overall but the trust was still, at times below the national average, the lowest being 85.5% in March 2013. Patients in A&E were waiting a long time to be assessed and treated by inpatient teams, and admitted to a hospital bed. The inpatient teams had a large geographical area to cover to see, review, treat and discharge patients and this further delayed the assessment and treatment of new patients coming into A&E. Patients were monitored for the length of time in A&E but the data was not always accurate or up to date or and some patients could be 'lost' in the system. We found patients had waited over three hours to see a doctor and some patients were waiting in the A&E for over 12 hours. There was a system for consultants to see new patient admissions over the

weekend but some medical inpatient outliers were not seen over the weekend by a medical doctor unless their condition deteriorated. They were not assessed, or considered for discharge.

- Patients had risk assessments but their medical records did not include care plans to address their individual needs. The trust was introducing new care plans but this was of particular concern for patients receiving end of life care and was having an impact on the effectiveness of care for those patients. In A&E, nursing staff were so busy that risk assessments and monitoring were not being appropriately documented for patients.
- Medicines were not always appropriately stored in locked cupboards and according to fridge temperatures. National guidance from National Institute for Health and Clinical Excellence (NICE) in 2007 on medication reconciliation was followed. This guidance identified that pharmacy staff should review patient medication within 24 hours of a patient admission as the potential risk of errors in prescribing could cause significant harm. The trust was achieving this for between 70 % to 80% of patients.
- The trust had had three never events (incidents that are so serious they should not occur) between December 2012 and January 2014. Only one of these had occurred since April 2014 and it was not related to a surgical procedure. These had been investigated to prevent reoccurrence.
- Overall compliance with the national Five Steps to Safer Surgery was improving.
- The support for patients living with dementia or patients who may have a learning disability was inconsistent.
- Patients who required end of life care were not be treated or supported according to national guidelines and their symptoms such as pain or distress were not appropriately managed. Staff did not have appropriate training and patients or their relatives or carers were not always involved in key decisions.
- The trust was investing in arrangements for early supported discharge. Discharge planning began at admission, and was done by coordinators and the community teams who worked in A&E and on the wards to facilitate discharge for patients who could go home. Patient discharge, however, was still being delayed for patients with complex needs and staff practices had not always changed sufficiently to improve discharge procedures. For example, Consultants on the short stay wards did two ward rounds a day as recommended by ECIST to improve discharge. Some medical patients on medical wards were not seen quickly enough by medical staff to plan discharge arrangements and medical staff did not always get involved in discharge meetings. These discharge delays placed further pressures on hospital beds.
- The trust was in the relatively unique position of having intermediate care community beds, and care pathways across adult and social care were being developed to avoid admission and aid early supported discharge. However, these needed to be sufficiently streamlined for joint working with social care services to be effective. Staff were positive about the medical day unit at Wycombe Hospital but identified the need for more strategies to avoid admission such as 'step-up' intermediate care beds.
- Protocols to transfer patients between hospitals sites had been improved and the transfer of critical care patients was managed appropriately if beds were required. Some transfers still happened for non-clinical reasons. There were still issues with working across two sites for emergency care. Patients who were wrongly admitted to Wycombe Hospital were transported to Stoke Mandeville but there could be delays if they were admitted through A&E. We observed that this had occurred for two patients, with one waiting a long time for pain relief medication.
- Representatives from the Patients Association worked with us during our inspection to retrospectively review how the trust handled complaints. They talked to staff, reviewed complaints and undertook a survey of 300 people who had complained; 105 (35%) replied. From the survey, approximately 50% of people thought their complaint had been poorly handled and 47.5% did not believe the trust would take appropriate action to prevent reoccurrences. The review found that the trust had been defensive about complaints. There had been delays in responding to them and there was no standard independent approach to investigating them and monitoring agreed action. Lessons learned were not widely shared.
- The trust complaints process was improving and they now offered all complainants face-to-face meetings and there was a new investigations template and monitoring arrangements. A Patient Experience,

Summary of findings

Themes and Lessons (PETAL) group had been established to identify, monitor and share themes from complaints, patient safety incidents and inquests. In 2011/12 no complaints had been upheld in the trust. There were 534 complaints in 2012/13 and all of these had been upheld. The trust was now responding to 84% of complaints within 25 days.

Professor Sir Mike Richards
Chief Inspector of Hospitals

12 June 2014

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Overall we rated the safety of services in the trust as 'requires improvement'. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital and Amersham Hospital.

Infection control was appropriately managed and incident reporting had improved. Staff were responding appropriately to patient risks. However, standards were not met for managing medicines, some essential equipment was not available in A&E, and patients did not have individual care plans. Nurse staffing levels were appropriate but the skills and experience of nursing staff did affect the continuity of care for patients. Senior medical staff presence had improved at the weekend for emergency patients but there was inadequate junior doctor cover for numbers of medical patients on inpatient wards out of hours and at the weekend.

Are services effective?

Good

Overall we rated the effectiveness of the services in the trust as 'good'. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital and Amersham Hospital.

Most patients were treated according to national evidence based guidelines and clinical audit was used to monitor standards of care. There were good outcomes for patients and mortality rates were now within the expected range. Seven day services were developing and were in place for patients requiring emergency care. However, the adequacy of training for junior doctors and skills and experience of nursing staff in areas, such as surgery, were a concern. Clinical supervision was a recent implementation and many staff had not had an appraisal. End of life care for patients did not meet national standards, this care was not monitored effectively and previous audits in this area had not led to change.

Are services caring?

Good

Overall we rated the caring aspects of services in the trust as 'good'. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital and Amersham Hospital.

Patients received compassionate care and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care and they received good emotional support from staff. There was outstanding care in the critical care unit and National Spinal Injuries Centre at Stoke Mandeville Hospital where staff built trusting relationships with patients and patients were involved in setting their own treatment outcomes and goals. There were areas of concern in ward areas where staff were busy and acknowledged themselves that they did not time to provide the level of support that patients needed.

Summary of findings

Are services responsive to people's needs?

Requires improvement

Overall we rated the responsiveness of services in the trust as 'requires improvement'. For specific information please refer to the reports for Stoke Mandeville Hospital, Wycombe Hospital and Amersham Hospital.

The hospital was busy during our inspection and under pressure. Patients had long waiting times in A&E to be assessed, treated and admitted to hospital in A&E. One patient had waited for over 16 hours on a trolley. Patients were waiting over the national waiting time of 18 weeks for elective or day case surgery. There were discharge delays for patients with complex needs. Patient information was mainly available in English though interpreter services were available. The support for patients living with dementia or with a learning disability was inconsistent. How services handled complaints was improving but some services were not responding to complaints within the trust target of 25 days.

Are services well-led?

Requires improvement

The trust leadership was rated as 'requires improvement'. Many of the executive team were new in post in the last 12 months and they have acknowledged that the trust was on a journey. We have confidence the trust is moving in the right direction. Staff told us the trust was more positive and open and there was a clear focus on quality and safety.

Since entering special measures the trust had work hard to improve and had made significant progress. Most of the trust's 25 point Keogh Mortality Review action plan was completed and the trust had developed a quality improvement strategy for continuous improvement. New services had been introduced and reorganised to manage the flow of patients through the hospital and improve the emergency care of patients. Governance arrangements were comprehensive and quality and performance were monitored for each service and displayed in ward areas for patients to see. The trust had engaged with the public to improve services.

The trust still needed to develop service strategies so that services could be better led. Staff were constantly managing capacity and service pressures and were uncertain about the sustainability of some services. Staff had felt that they had not been listened to about the reorganisation of some services and this had had deleterious effects on patient care. Staff engagement needed to improve to ensure priorities and the pace of change were agreed, understood and implemented.

Summary of findings

What people who use the trust's services say

- We held two community focus groups that were run by Regional Voices for Better Health. There were 15 participants in total representing individual views as well as community and voluntary organisations. The groups identified the following concerns:

1. Complaints were not handled well. People did not feel listened to and the trust was 'defensive', there were delays in responses to complaints and there was no evidence of action taken in response.
2. Discharge processes were sometimes inappropriate, discharge could be delayed on the day as doctors or medicines were unavailable, and patients did not receive legible and understandable information.
3. There was a lack of caring and responsiveness with staff.
4. Staff do not know how to care for vulnerable patients living with dementia or a learning disability.
5. Concerns about the trust ability to cope with service demands.
6. The lack of patient choice and flexibility in outpatient appointments, delays in appointments and test results and delays of over three weeks in receiving outpatient letters.
7. The fact that staff shifts were organised around staff rather than the continuity of care for patients and seven day working was not in place.

- Positive experiences were shared about the Wycombe Birth Centre, good clinical care for patients having day surgery, some good care in A&E, the breast screening unit service and that the appointment system in outpatients was beginning to improve.
- We spoke to 12 people at our listening events. Some people told us about us that they had good care at Stoke Mandeville Hospital and were kept informed. However, people had concerns about the care of older people with dementia at Amersham Hospital and long waiting times in A&E at Stoke Mandeville Hospital for frail older people. People also told us about delays to surgery and delays in getting a hospice bed. Some people told us that the trust did not handle complaints well, they had not been listened to and the trust response was delayed. Many people told us that outpatient clinics were good and they were well informed, but they also said that appointments were not coordinated and booking clinics could be complicated.
- Between September 2013 and January 2014 a questionnaire was sent to 850 recent inpatients at the trust as part of CQC Adult Inpatient Survey 2013. Overall trust was rated the same as other trusts. Comparison with the Adult Inpatient Survey in 2012 showed that the trust had improved its performance overall. The survey asked questions about waiting times for appointments, waiting for admission to a hospital bed, the hospital environment, having trusting relationships with doctors and nurses, care and treatment and operative procedures, being treated with dignity and respect, and leaving the hospital. However, patients rated the trust worse than other trusts for being given information about their condition in A&E, and for being given information on health and social care services on discharge and on the letters written by the trust to their GP that were understandable.
- In December 2013, the trust performed above the national average in the inpatient Family and Friends Test. The trust scored significantly lower than the national average for the A&E test.
- The trust had 294 reviews on the NHS Choices website for Stoke Mandeville Hospital (January 2013 to February 2014), Wycombe Hospital (January 2013 to February 2014) and Amersham Hospital (July and December 2013). Overall, it scored 4 out of 5 stars. The highest ratings were for cleanliness, excellent care, respectful and dedicated staff, and good aftercare. The lowest ratings were for overcrowding, discharge arrangements and waiting times.
- Patient-Led Assessment of the Care Environment (PLACE) is self-assessments undertaken by teams focus NHS and independent healthcare staff and also the public and patients. They focus on the environment. In 2013, the trust scored below the national average for cleanliness; privacy, dignity and well-being; facilities; and food and hydration. Only Stoke Mandeville Hospital had facilities, food and hydration identified as being above the national average.

Summary of findings

- The Survey of Women's Experiences of Birth, CQC, 2013 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth.
- During our inspection, patients told us staff were "busy" but caring, helpful and supportive.

Areas for improvement

Action the trust MUST take to improve

- Patients in A&E must be assessed by an appropriate specialist inpatient team in a timely way so that their treatment is not delayed. There should be clear standards to escalate patients who have long waiting times in A&E.
- The decision to admit patients must be made earlier by the A&E team. Patients waiting over 12 hours in A&E need to be accurately and appropriately identified, and the number significantly reduced.
- The accident and emergency (A&E) department must ensure that appropriate equipment is available and checked regularly to care for patients in the resuscitation bays, 'majors' area, initial assessment and treatment (IAT) and triage area.
- The procedures and facilities in the treatment room on Ward 16B need to change to ensure that medicines can be prepared safely.
- Medicines must be appropriate stored in locked cupboards and fridge temperatures need to be regularly checked, recorded, retained and acted upon.
- The appropriate medicines for end of life care must be available to avoid treatment delays.
- Care plans need to be developed for all patients.
- Patients at the end of life must have person-centred, holistic plans of care to enable staff to assess and treat patients effectively.
- 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms must be accurately completed and records of end of life discussions with patients must be documented.
- Patients at the end of life should be treated according to the National Institute for Health and Care Excellence (NICE) 'End of life care for adults quality standards' (NICE, 2009).

Good practice

Outstanding practice

- The stroke unit, also at Wycombe Hospital, was highly regarded in the region. Outcomes for patients were good and 'door to needle time' for clot-busting medication and specialist assessment were significantly better than in other trusts.
- The cardiology service, at Wycombe Hospital, had better response times than the average for England for reperfusion therapy for patients who presented with ST segment elevation myocardial infarction (STEMI).
- The 'Evian Project', was a multi-professional group led by the consultant nurse in critical care. This has improved the hydration of patients in the trust.
- The care and emotional support for patients in the critical care unit and National Spinal Injuries Unit (NSIC) were outstanding
- The trust had a 'Reflections at Birth' initiative for women. Women were asked to complete a 'birth reflections' questionnaire one month after the birth of their child and their answers were used to inform and improve the quality of the service.
- Where appropriate, children had pre-operative assessments done by phone to reduce the need for additional visits to the hospital.
- The children's outreach nurses supported early discharge for children. This included developing links with community nursing services, GPs, health visitors, education, occupational therapy and physiotherapy services.
- The NSIC was a centre of expertise and was internationally accredited. Patients were involved in setting their own treatment goals and outcomes. The centre carried out extensive research.

Summary of findings

- The multidisciplinary team approach in the Buckinghamshire Healthcare Rehabilitation Unit (BHRU) at Amersham Hospital to coordinate care included involving patients in setting their own treatment goals and outcomes for their care and rehabilitation.

Buckinghamshire Healthcare NHS Trust

Detailed Findings

Hospitals we looked at
Stoke Mandeville Hospital; Wycombe Hospital and Amersham Hospital

Our inspection team

Our inspection team was led by:

Chair: Heather Lawrence, Non-Executive Director, Monitor

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

The team of 36 included CQC inspectors, a pharmacist inspector and analysts, the medical director quality and service design, NHS England, a chief nurse and director of patient experience, consultant in emergency medicine, consultant in obstetrics and gynaecology, a professor and consultant in orthopaedic surgery, a consultant adult and paediatric cardiothoracic anaesthetist, senior clinical fellow in emergency medicine , a junior doctor, a midwife supervisor of midwives, a director of nursing, a theatre nurse, a nurse practitioner in cancer and haematology, a patient experience matron in A&E and ophthalmology, a nurse in paediatrics and child health, an associate director for the division of medicine and professional lead for therapies, student nurse, patient and the public representatives and experts by experience. The Patients Association was also part of our team to review how the trust handled complaints.

Background to Buckinghamshire Healthcare NHS Trust

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

Buckinghamshire Healthcare NHS Trust was formed in a merger of the acute and community hospitals in 2010. The trust had faced some financial challenges and had

developed services across Buckinghamshire where most emergency and inpatient services were centralised at Stoke Mandeville Hospital. In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in July that year. After that review, the trust entered special measures because there were concerns about the care of emergency patients and those whose condition might deteriorate. There were also concerns about staffing levels (particularly of senior medical staff at night and weekends), patients' experiences of care and, more generally, that the trust board was too reliant on reassurance rather than explicit assurance about levels of care and safety.

At the time of the inspection, the executive team was going through a period of change. A new trust Chair had been appointed to start in March 2014, and a new chief nurse in April 2014. The medical director, chief operating officer and director of human resources were all new appointments within the past 12 months.

The inspection team inspected the following core services :

- Accident and Emergency
- Medical care (including older people's care)
- Surgery
- Intensive / Critical care
- Maternity and Family Planning
- Children and young people's care
- End of life care
- Outpatients

We also inspected the National Spinal Injury Centre at Stoke Mandeville Hospital.

The minor injuries and illness unit at Wycombe Hospital was not inspected as this was managed by the Buckinghamshire Urgent Care 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?

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

We held two community focus groups on 5 March 2014 with voluntary and community organisations were held specifically for Stoke Mandeville Hospital. The focus groups were organised by Community Impact Bucks in partnership with Raise, through the Regional Voices Programme. This aims to listen to the views of people about services that may not always be heard.

We held two listening events, in Aylesbury and Wycombe, on 18 March 2014, when people shared their views and experiences of Stoke Mandeville Hospital. Some people who were unable to attend the listening events shared their experiences via email or telephone.

We carried out an announced inspection visit on 19–21 March 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections between 7pm and 11pm on Friday 28 March 2014 and between 6pm and 10pm on Saturday 29 March. We looked at how the hospital was run at night, the levels and type of staff available, and how they cared for patients.

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

Detailed Findings

Facts and data about this trust

Buckinghamshire NHS Trust: Key facts and figures (Latest data from March 2014)

Context

- Around 731 bed
- Population around 346,000
- Staff: 5,750
- Deficit: £1.8m in 2012/13

Activity

- Inpatient admissions: 91,307pa
- Outpatient attendances: 473,949pa
- A+E attendances: 93,806pa
- Births: 5,684pa

Beds and Bed occupancy

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

Intelligent Monitoring – (March 2014)

	Items	Risks	Elevated	Score
Safe	8	1	0	1
Effective	32	0	0	0
Caring	10	0	0	0
Responsive	11	2	0	2
Well led	25	2	1	4
Total	**86**	**5**	**1**	**6**

Safety

- 3 never events (2 previous Never Events now reclassified under STEIS as serious incidents).
- STEIs 127 SUIs (Dec 2012-Jan 2014)
- NRLS Deaths 10

  Severe 31 Moderate 833

- Safety thermometer
  - Pressure ulcers - High but variable
  - VTE - High
  - Catheter UTIs - High
  - Falls - Low but variable
- Infections
  - Cdiff 34
  - MRSA 0

Effective

All within expectations

Caring

- CQC inpatient survey - within expectations
- FFT Inpatient : Above England average overall

  A+E: Below England average

- Maternity survey 2013: within expectations
- Cancer patient experience survey
  - Performed better than average for 5 out of 69 questions and worse than average for 8 out of 69.

Responsive

- A+E 4 hr standard – Overall below. Down to around 85.5% at some points but improving.
- A+E left without being seen: worse than average.
- Cancelled operations: average
- Delayed discharges: average

Well led

- Sickness rate 4.2% (England average = 4.2%)
- Agency 3.7% (average to area)
- FTE nurses/bed day 2.06 (above average)
- Staff survey 2013 – 28 questions
  - 1 much better than average
  - 4 tending towards better than average
  - 5 Neutral
  - 8 tending towards average
  - 10 worse than average
- GMC survey: 20 area's worse than expected and 5 better than expected.

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

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

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

- Overall satisfaction
- Clinical supervision

Detailed Findings

- Adequate experience

Are services well-led?

Requires improvement

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

Summary of findings

The trust leadership was rated as 'requires improvement'. Many of the executive team were new in post in the last 12 months and they have acknowledged that the trust was on a journey. We have confidence the trust is moving in the right direction. Staff told us the trust was more positive and open and there was a clear focus on quality and safety.

Since entering special measures the trust had work hard to improve and had made significant progress. Most of the trust's 25 point Keogh Mortality Review action plan was completed and the trust had developed a quality improvement strategy for continuous improvement. New services had been introduced and reorganised to manage the flow of patients through the hospital and improve the emergency care of patients. Governance arrangements were comprehensive and quality and performance were monitored for each service and displayed in ward areas for patients to see. The trust had engaged with the public to improve services.

The trust still needed to develop service strategies so that services could be better led. Staff were constantly managing capacity and service pressures and were uncertain about the sustainability of some services. Staff had felt that they had not been listened to about the reorganisation of some services and this had had deleterious effects on patient care. Staff engagement needed to improve to ensure priorities and the pace of change were agreed, understood and implemented.

Our findings

Culture within the service

- The Keogh Review had identified that the trust was previously one that had promoted reassurance over assurance. There was a 'defensiveness' about quality indicators and the focus had been on explaining numbers rather than on understanding their meaning in terms of quality and the patient experience. Financial pressures seemed to have been the driver and these had compromised quality. Staff considered that changes to the leadership team were empowering them to make decisions at a local level, and they were positive that there would be fewer of the hierarchical and controlling constraints that had been in place before.
- Staff told us being in special measures was "difficult" and "tough to take" because all staff were motivated to provide good-quality care. However, past problems were recognised and the trust was moving in the right direction. Overall, staff said that the trust culture was more open and positive and staff felt that their concerns and ideas were now beginning to be listened to.
- The trust leadership described itself as "on a journey" of cultural change from board to ward and it was using governance, leadership programmes and staff engagement initiatives to achieve this. In 2013, the trust had undertaken a self-assessment of its safety culture using the Manchester Patient Safety Framework (MaPSaF) tool. The self-assessment was undertaken at various levels of the trust from the board down through divisions, service delivery units and individual teams. The results indicated that the predominant style was 'bureaucratic' with some 'proactive' areas. This is, the trust had steps in place to manage risks and there was the emergence of thinking about safety, but the culture was not yet 'generative' so that safety was integral to everything. Staff told us that they felt quality and safety were seen as a priority and increasingly identified as everyone's responsibility. They were now being supported and developed by the organisation to improve.
- The trust was open and transparent when working with partners to improve services. The Keogh Mortality Review and special measures had played a part. External facilitation to develop the board had also represented a shift in thinking towards an inherent need to continuously develop good quality and safe services. The trust had been open with partners when discussing challenges, risks and progress, and had shown resilience in the context of intense scrutiny and monitoring.
- The trust was promoting openness and transparency with staff and had an 'SOS' initiative for staff to speak out safely and report on incidence and performance concerns.

Public and staff engagement

- The trust had undertaken a series of public consultation meetings known as 'Big Conversations' between November 2013 and February 2014. The themes that

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emerged showed that people were positive about their care and considered outcomes of care to be good. They identified problems with the cancellation of outpatient appointments and long waiting times, hospital discharge and communication, particularly around test results. The patient experience was not always good. The trust was acting on these issues, revising administrative processes and inviting people to be involved in initiatives such as 'sit and see' so that they could assess and feedback on changes in care and services.

- The Adult Inpatient Survey, CQC, 2013, identified that the trust performed similar to expected in obtaining the views and experiences of patients on the quality of their care. The trust had introduced patient experience 'trackers' to collect real-time information on inpatients, and the information about the performance of the ward or department against a range of measures was displayed at the entrance to the ward and in the corridors. These displays were visible to staff, patients and visitors, and helped to promote a culture of openness. The displays were called, 'You said… We did' in response to complaints and concerns. Information from the Friends and Family Test, and quality and safety information (for example, results from audits of hand hygiene, and numbers of falls and pressure ulcers), were also included.
- The NHS Staff Survey (2012) identified that the trust was in the bottom 20% of trusts nationally for engagement and staff contributing to improvement at work. Work pressures, motivation and satisfaction were either worse or tending towards worse than expected, and this had only improved slightly since the 2012 survey. There was a difference between the survey results and the enthusiasm and commitment of staff that we observed during our inspection and were communicated in focus groups and staff drop-in sessions. Staff reiterated that the trust was on a journey and moving in the right direction. The new divisional structure was still being developed and some staff felt their areas were being 'lost' in the size of the division. Staff considered the trust still had some way to go in ensuring staff concerns were listened to, and in getting the balance right to match priorities with the pace of change. There were a few identified tensions between clinical staff and managers in the NSIC and the accident and emergency (A&E) department, which could affect patient care if they remained unresolved.
- The trust had invested in staff and undertaken a number of service changes to develop safe and sustainable services. However, many of the problems, such as pressure in A&E and the lack of available beds in the hospital Stoke Mandeville Hospital, were still continuing. Services were recognised as being on a pivot edge and there were concerns that any sudden significant increase in demand could make the A&E and emergency care pathway unsafe. Despite the reorganisation of services staff practices were not coordinated and some staff practices had not changed to work with the new models of care. There were examples of organisational change, in A&E, medicine, surgery, and outpatients where staff had felt that their views had not been listened to, and there were examples where staff had not changed to respond to service pressures, particularly in the assessment, treatment and discharge of emergency medical patients. The trust had acknowledged that it needed to respond to staff concerns and improve staff engagement to ensure that organisational changes worked effectively.

Innovation, improvement and sustainability

- Staff at all levels, in all services, and at all hospitals told us that learning and improvement were important for them and for their managers. Most staff had appraisals and clinical supervision was recently introduced for nursing staff. There were times, however, when training and development activities for nurses and doctors were cancelled or postponed when there were shortages of staff. The National Training Scheme Survey, GMC, 2013, identified that the trust was performing worse than expected in emergency medicine; general medicine, geriatric medicine, trauma and orthopaedic surgery. The areas that were worse than expected were overall satisfaction, clinical supervision and adequate experience.
- In the NHS Staff Survey 2012, the trust was in the bottom 20% of trusts for staff who contributed to improvements at work. Staff in some areas were encouraged to learn and improve (for example, in maternity, critical care and the NSIC) but this was not apparent in all areas. The trust was promoting staff engagement on improvement and was partnered with Salford Royal NHS Foundation Trust. Learning collaboratives were being developed and one of the key features of this work was to understand that staff engagement should happen for a purpose and was less effective as general

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communication. The first learning collaborative with Salford was the focus on early recognition of the deteriorating patient. This had been positively received by the staff and the learning was valued by the trust.

- The trust needed to save 8% year on year from cost improvement plans (CIPS). The clinical lead from the service delivery units attended CIPS meetings to agree projects that were approved by the divisions. The trust was predicted to make savings of £21.4 million against an estimate of £24.4 million in 2014. Despite being under target, this was still a significant amount of cost savings for a trust that needed to develop and change. CIPS were being assessed in terms of their likely impact on quality of services and patient experience.