Care Quality Commission

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Wexham Park Hospital

Quality Report

Heatherwood & Wexham Park Hospitals
NHS Foundation Trust
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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	**Inadequate**
Accident and emergency	**Requires improvement**
Medical care	**Inadequate**
Surgery	**Inadequate**
Intensive/critical care	**Good**
Maternity and family planning	**Inadequate**
Services for children & young people	**Good**
End of life care	**Requires improvement**
Outpatients	**Requires improvement**

Summary of findings

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Overall summary

Wexham Park Hospital is the main site of Heatherwood and Wexham Park Hospitals NHS Foundation Trust and provides services to a large and diverse population of more than 465,000. The area it covers includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire and Windsor. The trust has approximately 3,200 staff and a total of 650 beds, with 588 on the Wexham Park Hospital site. The trust has recently increased the bed capacity to meet increased demand following an increase in its catchment area in accident and emergency (A&E), paediatrics and wards and had plans to open more capacity later in 2014.

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

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

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

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

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

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

The trust had a long history of turbulence, which was felt by our inspection team at Wexham Park. Financial shortfall and high turnover of senior leadership had resulted in poor outcomes in recent CQC inspections and expressions of increasing concern from multiple stakeholders. We found the trust had significant legacy from a history of financial challenges and the hospital had a culture that was not open with learning at its heart. Although the financial challenges had been addressed and improvements trust-wide were beginning to be made with external support from agencies, the trust remained very challenged. The future sustainability of the trust and its hospitals remained a concern. Although efforts had recently been made in response to concerns raised by CQC about Wexham park Hospital, they were still very much in their infancy.

The culture was one of learned helplessness and accusations of bullying and harassment were seen

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throughout. Although the chief executive was reported to have high visibility and communicated regularly with the frontline, she had recently resigned and was due to leave in March 2014.

The lack of bed capacity in the hospital meant that many patients were moved from ward to ward during their stay, which impacted on their continuity of care and consultants being unaware of where their patients were in the hospital.

Staff stated they did not always report incidents or concerns because when they had done so previously, there had not always been any feedback and nothing had changed as a consequence. There was a consistent theme that learning was not implemented to improve patient care.

Cleanliness and infection control

Infection rates were in line with the national average. There were still concerns regarding infection control in some areas of the hospital but improvement been made since CQC raised concerns CQC during the inspection in October 2013. The trust had carried out a full deep clean of the whole hospital recently to good effect.

Staffing

There was high use of agency and locum staff, both in nursing and medical staffing. The trust recognised it had a high turnover of nursing staff and was considering approaches to retain and recruit nurses at the time of our inspection. During the inspection we noted agency staff were not consistently being appropriately checked or given an induction on arrival to the ward.

Staffing in radiology was a particular concern. There were 11.7 vacancies for radiographers, although the trust was in the process of recruiting. The radiology department consistently operated with agency radiographers every weekend and there were no plans in place to change this approach.

There were low levels of staff satisfaction and many reported concerns about a 'bullying and harassment' culture from senior managers and above. There was a significant level of conflict within the organisation among medical staff, which was impacting upon effective multidisciplinary working. Clinical engagement through the hospital was relatively low, with evident conflict and lack of belief in managers from many clinicians. The trust was aware of this and had gained external support to take steps to improve this.

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?

Inadequate

The safety of the services at Wexham Park Hospital was inadequate.

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

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

Escalation beds had been opened at short notice, which were staffed largely by agency. Many had not worked in the trust previously and we were concerned by their lack of induction to the wards.

There was a lack of a genuine safety culture, with the exception of the critical care unit and the children's and young person's department. The culture within the hospital contributed to discouraging staff from reporting incidents due to the lack of feedback and subsequent change. This was consistently a lost opportunity to improve practice and outcomes. Although there were individuals and groups of staff who took the time to progress initiatives, this was the exception. This could result in the organisation not being aware of its key risks.

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

The completion of the World Health Organisation's (WHO) surgical safety checklist (a nationally recognised tool to reduce errors occurring in theatres) was not consistently being completed. The trust was aware of the low compliance but no clear actions were being taken to improve it.

Some staff did not have up-to-date training due to the short staffing on the ward areas. However, there were systems in place to follow up those that did not attend or whose training was out of date.

Patient records had improved in some areas but there were significant gaps in patient records not including the appropriate information.

Are services effective?

Requires improvement

The effectiveness of the services at Wexham Park hospital overall required improvement, but there were inconsistencies throughout the hospital.

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

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

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

Although we found good multidisciplinary working in many areas, there was a lack of consistency in multidisciplinary working trust-wide. Some groups of consultants were not working collaboratively, which was impacting on multidisciplinary working being common practice throughout the hospital. However, there were some areas where multidisciplinary working was effective, including orthopaedics.

During the inspection it was noted that antibiotics were not being prescribed in accordance with the trust's policy on medicines management. Appropriate antibiotic use is important to prevent anti-microbial resistance and antibiotic related infections such as clostridium difficile.

Are services caring?

Requires improvement

The services at Wexham Park Hospital were, in the majority, found to be caring, but there were areas that required improvement.

The Friends and Family test at Wexham Park Hospital was below the national average with a score below the national average for inpatients in December 2013 (62 against a national average of 71). In the A&E department, the Friends and Family test scored well below the national average. In December 2013, they scored 23 against a national average of 56.

Members of the public expressed their concern to us at the listening event regarding poor care and the loss of dignity that they and their relatives experienced following treatment at the Wexham Park site.

We witnessed staff in some areas (services for children and young people, critical care and end of life care) deliver kind and compassionate care. But in others, due to the pressures placed upon them, staff were not always able to provide the amount of emotional support that patients wanted and deserved.

Are services responsive to people's needs?

Inadequate

The services at Wexham Park hospital were not considered to be responsive to people's needs.

The trust was very busy and since January failed to meet national targets to admit, transfer or discharge patients from the A&E department within four

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hours. In addition, the trust has been predominantly performing much worse than the England average with patients waiting between four and 12 hours following the decision that they should be admitted. In order to meet the four-hour target, some patients were noted to be admitted to a ward without having a diagnostic procedure, which delayed their diagnosis.

In order to increase capacity, extra beds had been opened, but there was little evidence of initiatives to try to reduce unnecessary admissions. Discharge planning was not initiated until patients were medically fit and discharges were delayed in many cases due to a shortage of radiology, physiotherapy, and occupational therapy assessments being completed in a timely manner.

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

Lack of resources and staffing in radiology resulted in diagnostic procedures not being carried out in a timely manner. Once the procedure was done, there were also delays in reporting the result. These delays may impact on the patient's diagnosis and appropriate care being provided, as well as delaying their discharge. At the time of the unannounced inspection, there were inpatients that had been waiting for 12 days for an X-ray, 10 days for a CT scan, 10 days for an MRI scan and eight days for ultrasound scan. The MRI machine was out of use as the lift was broken and this had not been reported as an incident as it persistently caused problems and staff didn't feel it made a difference. In outpatients, delays for an appointment for X-rays dated back to November 2013, ultrasound and CT scans delays dated back to 5 December 2013 and MRI scans to 15 January 2013. This resulted in patients attending for a follow-up appointment in the outpatient department without their diagnostic procedure being done.

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

The hospital's outpatient booking system was not working effectively and insufficient work had been done to improve the booking and appointments systems, waiting times, and the cancellation of clinics.

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

Are services well-led?

Inadequate

The services at Wexham Park Hospital were not consistently well-led. There were some instances of good leadership at ward level and in some specialist areas. However, at divisional level and board level leadership was considered inconsistent. While many members of staff recognised the regular communication from the chief executive, they did not feel there was clear

leadership or visibility from other members of the executive team. The high turnover of executive team members and the recent resignation of the chief executive impacted on the morale of staff, who referred to the trust as 'rudderless'. In addition, Wexham Park Hospital did not have a clear vision for staff to align to or aspire for. The lack of clarity about the hospital's future left many staff feeling disempowered.

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

The financial challenges that the hospital has faced over recent years had resulted in the executive team being focused on finances to the detriment of quality and patient experience. Although we noted that there had been a shift back towards patient centred quality care this was still at an early stage and that the trust board showed a variation in understanding of the key issues facing the trust.

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

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

While there were groups who were engaged with the holistic patient experience, some consultants were seen to prioritise their individual working preferences and displayed dysfunctional working practices to the detriment of patient experience at Wexham Park.

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

There was a widespread reference to bullying and harassment culture among staff groups at various levels and they felt this impacted on their ability to care for patients effectively. The executive team was aware of some areas where bullying and harassment concerns had been raised and had commissioned an independent panel to review a number of the trust's key policies in relation

to raising concerns. This had found that significant improvements were needed to ensure they were effective. At the time of the inspection this review had only recently been carried out and therefore it was too early to note any evidence of actions being taken to improve these policies.

In many cases, staff said that they did not raise any concerns or report incidents because when they had done so in the past nothing had changed as a consequence to improve patient care. Staff did state that they had seen change occur since CQC raised concerns, but they weren't listened to themselves when they raised the same concerns.

Members of the executive team were unanimously concerned about the perceived instability in the future of the hospital and recognised the need for long term significant support in order to achieve a sustained and improved future for the hospital and trust overall. Some of the executive directors did not have confidence that, as a board, they could make the required significant improvements within an acceptable period.

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

Accident and emergency

Requires improvement

A&E had made significant improvements in the last 12 months following enforcement action taken by CQC. However, a number of significant improvements were still needed for the department to reach a 'Good' standard.

The vast majority of the time, the department provided safe care to patients. In particular, we found the Early Detection of Deterioration (EDOD) scoring system to be effective and well managed. This meant that, if patients rapidly deteriorated, the risk of them not being treated safely was reduced.

However, we were concerned that some patients spent a long period in A&E before a bed could be found in the hospital. For the first five weeks of 2014, the trust managed to reach the national four-hour target on just one occasion. In addition, the trust had been predominantly performing much worse than the England average, with patients waiting between four and 12 hours to be admitted. Since 2013, waiting times had steadily worsened.

There were no formal comfort rounds performed in the department and the patients we spoke to said that they had not been offered food or drink. Poor communication was also a commonly heard complaint. Patients were often on trolleys for over six hours, after which their risk of pressure ulcers increases. However, no risk assessments were undertaken.

Consultants displayed good knowledge about delivering the best clinical practice and the department participated in the national College of Emergency Medicine audits. We found that the clinical lead had a good knowledge of these audits and the issues that they had identified for A&E, but less certainty regarding the ways in which improvements were going to be implemented.

Medical care (including older people's care)

Inadequate

The medical care of patients was too variable in its quality and safety. There were capacity constraints within Wexham Park Hospital and the high demand for beds led to patients being moved from ward to ward on numerous occasions for non-medical reasons. This resulted in a poor patient experience and impacted on their treatment due to inconsistency in continuity of care.

Temporary escalation ward space had been created to deal with the lack of capacity, but this was not always suitable for this purpose. In addition, many wards needed to have general medical patients on them, which impacted on the ability of other departments, such as cardiology, to treat patients and cancellation of elective procedures was routine.

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Since CQC had raised concerns on medical wards following an inspection in October 2013, there had been new nurse management put in post and the staff recognised that in some instances improvements were being made to improve patient care. Although these changes were in their infancy, the staff felt the ward level leadership was improving.

There was a lack of permanent nursing staff on some wards, with a significant proportion of agency staff working on wards and caring for patients. During the unannounced inspection, all wards we visited had agency staff on the shift, and on one ward only agency staff were caring for the patients. This resulted in lack of continuity of care and treatment and, in some instances, poor knowledge of the patient's condition. Overall ward staff numbers were low and patients' care needs were not always being met. Patients were placed at risk of not receiving safe and appropriate care and treatment.

During the inspection it was noted that agency staff were not being appropriately checked or given an induction when arriving at the hospital. This meant that agency nurses were working on the ward without knowing where all equipment was kept and providing treatment to patients without them being checked as appropriately trained in all instances.

There had been a recent increase in junior doctors and this had improved their availability at night and weekends. Although clinical engagement was improving in certain areas, such as cardiology, this was not consistent throughout the directorate and this impacted on the ability for a learning and safety culture to be embedded throughout. There was a lack of clinical ownership of the need to drive improvements and for the monitoring to ensure that it was achieved and sustained.

Surgery

Inadequate

While many aspects of surgical care were safe, some areas required significant improvement. These included completion of the World Health Organisation's (WHO) surgical safety checklist (a nationally recognised tool to reduce errors occurring in theatres). They also need to improve staffing levels and reduce the number of agency staff used on wards. When incidents occurred and were investigated, the learning from this was not always implemented to prevent it happening again and improve care.

There were concerns about the use of the theatre recovery area as a bedded area for patients when there not enough beds in the hospital wards. This meant patients were being recovered in areas where other patients were being visited by relatives, and eating and drinking.

Surgical procedures were effective and outcomes for patients were good. Data from national audits and databases showed that surgical outcomes were at, or close to, the national average.

We found that many of the staff we spoke with were compassionate and caring but they felt that workload pressures did not always give them

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sufficient time to spend with patients. Many patients spoke highly of surgical and ward staff, although there were some exceptions. Patients often felt that staff were responsive to their needs but that the hospital's systems and processes were not.

One significant example of the hospital's lack of responsiveness included the high number of cancelled or delayed surgical operations at short notice and the frequency with which patients were moved from one ward to another. There was a large volume of outliers (medical patients) on almost every surgical ward, which meant that many patients lacked continuity of care because they were being moved to different wards.

Inpatient surgical admission wards were well-led, but the hospital's surgical division as a whole was not considered well-led due to various concerns associated with consultants not engaging with one another and as a consequence multidisciplinary working being ineffective. Surgical staff told us there was a culture of bullying and staff were discouraged from raising concerns. When staff raised concerns or suggested improvements, they said these were ignored, which made them feel disempowered and unable to effect necessary improvements in care.

Governance arrangements were poor, which meant systems and processes were not being monitored effectively. Multidisciplinary meetings were not consistently taking place, although good practice was noted in orthopaedics. This meant that all groups of staff were not reviewing cases as a team to aim to learn and improve patient care. There were inadequate systems for monitoring the performance of surgeons.

Managers were slow to implement changes as a result of incidents and never events (which is a nationally defined largely preventable patient safety incident).

Intensive/critical care

Good

Patients received safe and effective care when admitted to ITU. Patients and relatives we spoke with were very pleased with the care they received in ITU and spoke highly of the staff.

Clinical outcomes for patients in the unit were good, often above the national average.

Staff worked well together as a team and were enthusiastic about their work. However, we found the unit was functioning with an unacceptably high staff vacancy rate. This was identified on the trust's divisional risk register and recruitment was in progress.

There was also a high number of non-clinical transfers of patients from ITU to other hospitals due to lack of capacity of their intensive care unit. Patients who needed critical care were sometimes cared for by recovery staff in theatre because there were no available beds in ITU.

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Maternity and family planning

Inadequate

We had significant concerns with regards to the quality and safety of care provided at Wexham Park hospital. There was an overall prevailing culture of bullying and lack of joined-up working across the multidisciplinary team. Incidents were not always being reported and there were accusations of improper downgrading of their severity alongside suggestions of defensive practice. Lack of leadership within the unit had left staff disengaged and distracted staff from patient centred care.

Although midwife to birthing ratios were often satisfactory, the department was heavily reliant on agency staff as there were 26.4 whole time equivalent vacancies for midwives. The consultant cover is in line with Royal College of Obstetricians and Gynaecologists guidelines, though we were given examples of how overnight staffing arrangements meant that some mothers were unable to deliver at the originally planned time.

We found that not all clinical guidelines had been updated, including those pertaining to emergencies such as maternal haemorrhage. Concerns had been raised both internally and externally with regards to the caesarean section rate for the unit. There did not appear to be a robust action plan to address this.

According to CQC's maternity survey 2013, the trust performed in line with other maternity units, although we received mixed feedback during our inspection. Some new mothers were very positive whereas others gave us examples where they reported staff to be rude and not communicate well with them.

Services for children & young people

Good

The care for children and young people was good. The treatment and care needs of children and infants were assessed and planned from referral to discharge, taking into account their individual needs and with reference to their parents. We found that children and infants received safe and effective care throughout the hospital.

We found that the paediatric services in the hospital were well-led by a very enthusiastic and committed team of staff.

Children who spoke with us said that the staff were kind and caring and that they received information that helped them understand what treatment and care they were receiving. The majority of parents who spoke with us commented positively on the service, the quality of care, and how both they and their child were treated with dignity and respect.

Staff were aware of best practice guidance for the safe and effective care of children and infants. The health and wellbeing of children, young people and infants was monitored using recognised assessment tools.

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Children received pain relief according to their needs and with prescribed medicines. Staff were aware of their responsibilities for safeguarding children and arrangements were in place for looking after vulnerable children and infants.

End of life care

Requires improvement

Patients received safe and effective end of life care at Wexham Park Hospital. Patients' care needs were being met and the service had established good working relationships with community services.

Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect by all staff they encountered.

Staff supported patients to be fully involved in their care and decisions. The end of life team was well-led at a local level, and staff were dedicated to improving standards of end of life care across the hospital as a core service for all patients who needed it.

However, the drive and vision was that of the palliative care leads and not through any trust-wide strategy, and providing good end of life care did not appear to be a priority for the trust.

There were capacity issues in the mortuary, which the trust was managing through extra capacity, but the pre-mortuary care provided by some of the nursing staff on some of the wards was not considered to be at the standard expected. This was recognised by the trust.

Outpatients

Requires improvement

We found that some improvements were required to keep outpatients services safe for people at Wexham Park Hospital. These included better infection control and systems to ensure that people received treatment in a timely way.

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 outpatient department was effective or responsive to patients' needs. Insufficient work had been done to improve the booking and appointments systems, waiting times, and the cancellation of clinics. This resulted in many patients experiencing significant delays when attending outpatient clinics. In some instances, patients either received two appointments or failed to receive one at all. Delays were also linked to delays in radiology department, which meant patients were not having investigations carried out as planned prior to a follow up appointment.

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 management level to improve communication, learning, and improvements in outpatients.

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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. Wexham Park Hospital scored below the national average for inpatient in December 2013 with a score of 62 against a national average of 71.

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

In the A&E department Friends and Family test, Wexham Park Hospital (excluding Heatherwood Hospital) scored well below the national average for the response rate and the score consistently. In December 2013, they scored 23 against a national average of 56, with a response rate of 10.1% 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.

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

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

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

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

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

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

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Areas for improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

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

Wexham Park Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Kathy McLean, Medical Director, Trust Development Authority

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of 32 included CQC managers, CQC inspectors, CQC analysts, executive directors, specialist consultants, doctors, clinical fellows, nurses, student nurse, patient and public representatives, Experts by Experience and allied health professionals.

Background to Wexham Park Hospital

Wexham Park Hospital is the trust's main site and provides services to a large and diverse population of more than 465,000. The area it covers includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire, and Windsor. The trust has approximately 3,200 staff and a total number of 650 beds, with 588 on the Wexham Park Hospital site. 61 of the beds at Wexham Park Hospital are used for maternity, 57 for children, 93 for surgery, 12 for critical care, and the remaining number for various medical specialities. The trust had recently increased the bed capacity in A&E, paediatrics and wards and had plans to open more capacity later in 2014. The trust's catchment increased as a consequence of the closure of an A&E department of another trust nearby in November 2012.

The trust became a foundation trust in 2007. In 2008/9, the trust faced significant financial challenges and in 2009/10 Monitor appointed a new chairman. At the time of the inspection, the executive team comprised members who were either interim appointments or relatively new in post, with only one member of the executive team in post for over three years. The chief executive had been in post for two years and four months (but had formally resigned, with a leaving date in March 2014) and the chairman had been in post for one year and three months. This instability in leadership, the financial challenges, and the absence of a consistent vision had evidently had an impact on Wexham Park Hospital's standard of care and culture.

Wexham Park Hospital was in breach of a number of regulations and, in many instances, it has been providing care below the essential standards, as we found during two previous CQC inspections in May and October 2013. In May 2013, there were particular concerns about the care provided to patients in A&E and the impact this had on the ability of in-patient wards to provide the essential standards of care that are required by the regulations. Following that inspection, we issued a warning notice to the trust against Regulation 10: Assessing and Monitoring the Quality of Service Provision.

Detailed findings

In October 2013, we followed up on the warning notice and found that the trust had made significant improvements in some areas, particularly in managing capacity issues in A&E at Wexham Park Hospital. However, during this inspection we found a number of significant concerns and issued six warning notices to the trust against Regulation 9: Care and Welfare of Service Users, Regulation 10: Assessing and Monitoring the Quality of Service Provision, Regulation 12: Cleanliness and Infection Control, Regulation 17 Respecting and Involving Service Users, Regulation 20: Records, and Regulation 22: Staffing. All these warning notices stated that Wexham Park Hospital must become compliant with all the regulations by 31 January 2014.

Following our inspection in October, we referred our findings to the local area team (NHS England), the General Medical Council, Monitor, the Health and Safety Executive and the commissioning department within the local authority. As healthcare regulator, Monitor subsequently appointed an improvement director to support the trust. We followed up the warning notices as part of our planned inspection in February.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. Our new intelligent monitoring model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Wexham Park Hospital was considered a high-risk service.

How we carried out this inspection

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

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

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

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

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

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

We talked with patients and staff from all areas of the hospital, including the wards, theatres, recovery, radiology department, outpatient services, and A&E. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

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

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

Requires improvement

Accident and emergency

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

Information about the service

The accident and emergency department (A&E) at Wexham Park Hospital receives all types of accident and emergency cases apart from major trauma cases, which are taken to other hospitals by the ambulance service. Most of the department, except for two areas, has been recently refurbished.

The adult emergency department saw about 74,000 patients last year. The paediatric emergency department was responsible for seeing and treating approximately 26,000 children during the year. This means that although the A&E was originally built for 70,000 attendances it is currently seeing in excess of 100,000. The trust anticipates that this figure will rise by 3% each year. The trust has recently introduced a new reception process for ambulance arrivals, which means that patients are assessed rapidly and tests and treatment are begun at an early stage. During our inspection, we spoke to approximately 34 patients and relatives and 21 members of staff, both clinical and non-clinical. We examined the medical records of 11 patients.

Summary of findings

A&E had made significant improvements in the last 12 months following enforcement action taken by CQC. However, a number of significant improvements were still needed for the department to reach a 'Good' standard.

The vast majority of the time, the department provided safe care to patients. In particular, we found the Early Detection of Deterioration (EDOD) scoring system to be effective and well managed. This meant that, if patients rapidly deteriorated, the risk of them not being treated safely was reduced.

However, we were concerned that some patients spent a long period in A&E before a bed within the hospital could be found. For the first five weeks of 2014, the trust managed to reach the national four-hour target on just one occasion. In addition, the trust had been predominantly performing much worse than the England average, with patients waiting between four and 12 hours to be admitted. Since 2013, waiting times had steadily worsened.

There were no formal comfort rounds performed within the department and patients we spoke to said that they had not been offered food or drink. Poor communication was also a commonly heard complaint. Patients were often on trolleys for over six hours, after which their risk of pressure ulcers increases, however no risk assessments were undertaken.

Consultants displayed good knowledge about delivering the best clinical practice and the department participated in the national College of Emergency Medicine audits. We found that the clinical lead had a

Requires improvement

Accident and emergency

good knowledge of these audits and the issues that they had identified for A&E, but less certainty regarding the ways in which improvements were going to be implemented.

Are accident and emergency services safe?

Requires improvement

Safety and performance

During our inspection, we found that A&E was clean and tidy with cleaners highly visible. We noted that staff regularly used hand gels and always used them when moving from one patient to another.

We spoke to a number of staff and examined the way in which patients were assessed when they arrived and throughout their stay in A&E. We found that there were no nursing risk assessments being undertaken when patients were admitted or throughout their time in the department. National nursing guidance states that when a patient is kept in a clinical area for more than six hours a nursing assessment should be carried out to identify their risk of developing a pressure sore or falling. Senior staff told us that as patients should not be in the department for longer than four hours, assessments were not routinely undertaken. However, we found that many people were in the department for more than 12 hours. Over the two days of our inspection we found that 52 patients had been in the department for more than four hours.

Staffing

We reviewed the number of registered nurses in the department, which was very busy during both days of our inspection. Staff told us that the department was usually busy and the number of patients in the department during our inspection was quite typical. We examined the nursing rotas across a four-week process and observed the actual number of nurses on duty. We found that there were always 20 nurses (as rostered) on duty, which, for the number of patients they had to look after, meant their ratio ranged from one registered nurse to four patients to one registered nurse to two patients. The department has recently increased its nursing establishment by 50%, which meant that, although the nurse to patient ratios were very good, the department was employing a large number of agency and bank staff. We found that the agency nurses were not always fully trained, briefed, or supervised. For example, we found that induction checklists had not always been completed.

Accident and emergency

A&E also employed four healthcare assistants (HCAs) per shift to provide cover 24 hours a day, seven days a week. The HCAs' focus was on ensuring that patients were properly supported with nutritional and personal care needs. This meant that the nurses were able to focus on providing more specialised nursing care to patients. There were now enough registered nurses and HCAs in the department to meet the care needs of people.

The College of Emergency Medicine recommends that an A&E department should have enough consultants to provide cover 16 hours a day, seven days a week. The trust currently does not meet this recommendation. There were seven permanent consultants in post (from a target number of 12) and two locums, between them working between 8am and 10.45pm. There was consultant cover nine hours per day at weekends.

Despite efforts by the trust to recruit new staff, A&E was under resourced for middle-grade doctors. Of the nine posts for middle-grade doctors, only six were filled by permanent staff; the trust relied on locums and training posts to make up the additional numbers. The trust had responded to the shortage of middle-grade doctors by increasing the number of more junior doctors. This had the advantage that patients waited a shorter time to see a doctor, but the doctors were less experienced and required more supervision. This could lead to patients taking longer to be diagnosed, treated, and moved to other parts of the hospital for admission.

The high number of locum doctors being used was problematic in some cases. There was documentary evidence in complaint statistics and clinical audits to indicate that the standard of locum doctors was inconsistent, which has led to a higher number of clinical errors and complaints from patients.

Learning and improvement

Senior managers in A&E had a good knowledge of the issues relating to safety standards for patients. They were all able to describe the processes the department used to identify, analyse, and learn from things that had gone wrong in the past. They were able to describe a number of specific cases in detail and set out how they had communicated the learning to staff. When serious incidents were identified, an independent senior clinician undertook a detailed investigation. We found investigation reports to be rigorous and open in their conclusions. This meant that the department learned when things went wrong and the risk to future patients was reduced.

We examined a number of 'root cause analyses' (this is the method by which clinicians establish how and why patient safety incidents happen); these had been undertaken thoroughly and identified changes to procedure that would be implemented in the future. Senior managers were clear that they played a role in leading this process. There were monthly clinical governance meetings that were chaired by the lead consultant for safety. The meeting looked at incidents where things had gone wrong and the reasons, and it then decided on how to make sure the same error did not occur in the future. For all staff who were unable to attend, learning was disseminated by email and newsletters, which we examined. However, there was a lack of clear guidelines to ensure that changes were embedded into practice, reducing the likelihood of changes becoming routine practice in the future.

Systems, processes and practices

The way the staff work has changed as a result of a recent refurbishment and new processes. The consultant on duty took an overseeing role, with other senior doctors in the rapid assessment area and in the 'Majors' area. Senior nurses also adopted an overseeing role, with each smaller area having a nurse responsible for care. Staff told us that there was some inconsistency in how effectively this was implemented, and it is clear that systems were still in the early stages of bedding in. It was also obvious however, that there was a clear intention to improve things now that the staff felt able to do so in a better environment and with improved processes available to them.

Although medical notes, including records of vital signs such as pulse and blood pressure, are kept on paper notes that stay with the patient, we found that nursing notes are entered and kept in an electronic format. This format consisted of a blank page that was completed by the nurse. Entries were not timed or a record kept of who made them. This created a risk that important information could be missed. We found that a patient

with a cannula fitted had no record of this in their notes. The risk is that without proper records patients may be 'missed' and not receive these important elements of care.

Medical staff told us that there was an effective system of clinical supervision. Each person had a named clinical supervisor who would hold regular meetings to discuss how practice could be improved. However, there was no process of sampling medical notes across the department as a way of assuring that good practice was being followed.

We did not find that call buttons were in use and instead staff told us that they relied on people calling them with their voices. This could lead to elderly or otherwise frail patients who were unable to raise or even use their voices being overlooked if they were in need of care and support.

We found that nurses were aware of safeguarding issues and the correct procedure to take if they identified an incident of abuse. However, Doctors did not display the same level of knowledge and stated they had not received training on safeguarding issues.

Senior staff told us that all X-rays were reviewed by a consultant radiologist to ensure that less experienced staff did not miss fractures. We spoke to a middle-grade doctor who told us that he had been advised that he had missed a fracture and given support in how to avoid such a mistake again. This meant that there was a process in place to identify errors in interpreting X-rays and learning was shared with staff. This reduced the likelihood of misdiagnosis for patients.

We found some examples of good practice. Following the issuing of new national guidance (Surviving Sepsis 2012) on dealing with sepsis (serious infection), the department had reviewed its own guidelines and processes. As a result, they had created a number of sepsis boxes that contained all the medication, equipment and guidance a clinician would need to respond to the risk of sepsis. The box included a flag to go on the patient's bed that told people that medication was time-critical. The department had reviewed the response times and found that sepsis treatment times and treatment had improved, which would lead to better outcomes for patients. Of note though, our medical team found when looking through notes on the Acute Medical Unit that the four patients with an admitting diagnosis of sepsis had not had their antibiotics administered prior to them being seen by the medical team.

Medicines were prescribed appropriately, however during the inspection we noted multiple occasions where patients were not administered their medication in a timely manner, which could result in their condition deteriorating. Appropriate arrangements were in place in relation to the recording of medicines. The prescriptions and records of administration that we looked at were clear. We observed that medicines were kept safely and locked away when not being dispensed.

Monitoring safety and responding to risk

Patients whose condition might deteriorate were monitored properly. An early warning process for rapidly deteriorating patients is managed by the 'early detection of deterioration' (EDOD) scoring system. Nurses monitored and recorded vital signs such as pulse and blood pressure and the EDOD system involved a system of scoring each one of the vital signs. If the patient's score reached a certain level, then an outreach nurse and doctor had to be called. We spoke to a number of nurses working on the ward and examined a number of medical notes where the scores were recorded. We found that nurses were making regular checks of patients' vital signs and were properly recording scores. This meant that the risk to patients of them not being treated quickly if they deteriorated was reduced.

In addition to the senior doctor and nurses being aware of the department, the A&E main office had a board round system four times a day where all the doctors and the nursing lead assembled in the A&E office and talked through each patient's care and treatment needs to ensure that every member of staff was aware of each patient. This process ensured that there was regular senior medical and nursing input into patients' care and reduced the risk of a patient failing to get the right treatment. There was also a system of medical handover in place.

There was a handover sheet to be completed by the nurse in charge at every shift change, which had recently been implemented. This handover sheet was not being completed in the majority of cases, which may result in pertinent information not being handed over or documented.

Requires improvement

Accident and emergency

Anticipation and planning

We looked at most of the resuscitation equipment that was used if patients stopped breathing or had a cardiac arrest in A&E and found that it was in working order and had been regularly checked. This meant that the unit was able to respond quickly in emergency situations with properly working equipment.

The department had set up an 'antidotes cupboard' that contained antidote drugs for a large number of possible circumstances. This meant that patients were more likely to get the antidote drug they needed in a timely way and would experience better outcomes.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Consultants displayed a good knowledge of up-to-date guidelines for delivering the best clinical practice. Staff were able to correctly talk through the correct pathways for conditions such as stroke, broken leg bones, and children's issues. However, we found that limited up-to-date clinical guidance was available to staff on the trust intranet. The guidance was neither A&E specific, trust-specific, or comprehensive. This meant that staff would sometimes have to refer to other sources or ask colleagues for advice when they came across a medical situation they were unfamiliar with. If advice is not available, there is a risk that treatment will be delayed or the most effective treatment will not take place. This was a particular concern, given the high use of agency and locum staff. When we spoke to the clinical lead for this area, they were aware of the issue and told us they were developing a plan to produce a comprehensive set of locally focused clinical guidance in the next few months.

Performance, monitoring and improvement of outcomes

The trust has undertaken a large number of national and local clinical audits that aim to identify how the trust is performing against other similar trusts and to identify areas for improvement. In addition, the department has undertaken specific audits managed by the College of Emergency Medicine around the areas of fractured neck femur, fever in children, consultant sign-off, and renal colic. We reviewed these audits and found that the department performed below average in most areas, with limited evidence of improvement. For example, patients who had suffered a broken femur had been offered less pain relief in 2012 than when the audits were conducted in 2004 and 2007. We found that the clinical lead had a good knowledge of these audits and the issues that they had identified for the department, but was not able to demonstrate any written or approved plans for how improvements were going to be implemented and changes made. This meant that learning from auditing clinical practice was not always being used to improve patient care.

Multidisciplinary working and support

Staff within A&E had good working relationships with other parts of the hospital and with local partners such as social services and GPs. Senior staff told us that the department had worked with local GPs to agree the best procedures for referring patients into the hospital. For example, the hospital has a surgical assessment unit and patients can be referred directly to this area without the need to go to the A&E department. Staff told us that GPs usually referred patients to the department with the correct paperwork and only if they really needed to be there. There were also good examples of where department staff worked well with social workers in the community to ensure prompt and effective discharge into the community. These good working relationships meant that patients were referred to the right areas of the hospital for their medical needs.

Medical teams work within the ED seeing patients with 'medical' problems, rather than such patients being assessed in a medical assessment unit. These teams were less responsive than the ED teams, resulting in longer waits for patients.

We found that there were specific issues with regards to how well the radiography department was supporting its A&E colleagues. A&E did not have its own X-ray facility and patients had to be taken to the radiology department. When a doctor decided that a patient needed an X-ray, there was a standard that this should be available within one hour. We found evidence from examining medical notes that doctors were often waiting for over two hours. Staff told us that they often waited longer during lunchtimes when there were fewer

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radiographers on duty. This delay may extend the time it took to diagnose and treat a patient, who may therefore experience poorer outcomes. Senior staff at the trust confirmed that there was a shortage of radiography staff and this had caused delays for all departments, including A&E. In some instances, patients that required a diagnostic procedure, such as a chest x-ray, were being admitted to a ward to meet the four hour target without the diagnostic procedure being done. This resulted in the patient having to wait longer for the procedure which may impact on the effectiveness of their diagnosis and treatment. This was recognised as an issue in many departments, including radiology.

Are accident and emergency services caring?

Requires improvement

Compassion, dignity and empathy

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate the NHS 'Friends and Family' tests for A&E and inpatient admissions. For August 2013 to November 2013, the trust score was 24 for the A&E department, which was significantly lower than the England average of 56.

We also found that A&E had a very low response rate in the friends and family test; in December 2013 the trust had a response rate of 10.1% compared with the England average of 15.3%. Senior managers we spoke with were aware of this low response rate but did not have a plan for how they could increase it.

We spoke with a large number of patients and their relatives during the two days of our inspection, some of whom were positive about the treatment they had received. For example, one person told us: "Over years they have saved my life and treated my family excellently." Another said: "I have been treated very well; I cannot fault the staff." However, an equal number of patients had concerns about their treatment. They told us: "I don't know what's going on." And another person said: "It all seems to take a long time." We found examples where patients who had been in the department for some time had not been fed. One patient told us: "I came in here last night and haven't had anything to eat. I am really hungry." A number of patients told us that they had asked for a drink but that it had not been provided. It is good practice for an A&E department to undertake 'comfort rounds' where people are asked at regular intervals if they need something to eat or drink or if they need support with going to the toilet. When asked about this, a senior manager told us that this was not necessary as patients do not stay long enough in the department to warrant it. In fact, people are spending extensive amounts of time in the department and some of them may not be receiving this basic care.

All the children and their parents or carers we spoke to were very positive about the care they received in the children's area of A&E. We found that staff were very caring and able to meet the needs of patients. There were always specially trained nurses on duty.

During our inspections we observed good care being given to patients in a friendly and considerate manner. We also observed that people's privacy was respected with curtains being drawn when personal care was being given. Staff also lowered their voices to prevent personal information being overheard by other patients.

Involvement in care and decision making

In the CQC 2012 In Patient survey two of the questions relate specifically to patients experience whilst in the A&E department.

For both of the questions "Were you given enough privacy when being examined or treated in the A&E department?" and "How do you feel about the length of time you were on the waiting list? (relating specifically to the time waiting for A&E)" The trust performed particularly badly.

Trust and communication

From speaking to patients and those close to them, we found that there was a constant theme relating to poor communication. One person told us: "Poor communication – we are not told what is going on." Another said: "I would rather know more what's going on."

One patient told us that she had been upset that two doctors had been standing at the bottom of her bed talking about her case as if she wasn't there. A number of patients had raised the issue that doctors did not introduce themselves to patients. The A&E senior managers we spoke to were very aware of this issue and

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knew that it was one of the main causes of patient complaints. They had recently spoken to all staff about being more polite and empathising with patients and had commenced an initiative entitled 'Hello, my name is' to encourage clinical staff to introduce themselves. Junior staff we spoke to said that they were aware of the importance of communicating respectfully with patients.

Emotional support

The interactions we observed between patients and staff were positive, with staff talking to patients in a kind, sensitive and responsive manner. However, patients raised a number of concerns with us during the inspection. One relative said that she had spent the whole night sitting with her sick elderly father and that at no time did anyone ask how she was coping or if she needed any support.

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

(for example, to feedback?)

Inadequate

Meeting people's needs

Trusts in England are given a target by the government for admitting, transferring, or discharging 95% of patients within four hours of their arrival in A&E. The trust's performance with regards to waiting times was inconsistent and the trust was rarely meeting the four-hour target.

For the first five weeks of 2014, the trust just managed to reach the target on one occasion. For the other four weeks, trust performance ranged from 81.8% to 89.4% w/e 5/1/14 – 89.4%; w/e 12/1/14 – 87.1%; w/e 19/1/14 – 88.9%; w/e 26/1/14 – 95.2%; and w/e 2/2/14 – 81.8%.

In addition, the trust has been predominantly performing much worse than the England average, with patients waiting between four and 12 hours following the decision that they should be admitted. In September 2013, the trust had 23% of people waiting between four and 12 hours. Performance has steadily worsened, which meant that people were spending longer than they should in the department.

The new rapid assessment process in A&E worked well and ensured that patients were seen and assessed quickly after they arrived by ambulance into the department. There was no similar system operating for patients with more minor conditions. Patients did however, wait a long time to be seen once in the main department, especially if they were waiting to see a doctor from one of the speciality teams. .

On the first day of our inspection, at 4.15pm there were 18 patients in the 'majors' area where the most seriously ill patients are looked after. For 10 of these patients it was noted that a 'decision to admit' (DTA) had been made, meaning that they should be moved to the main hospital wards for inpatient treatment, and 11 of them had been in the department for more than four hours. One of the patients had been in A&E for 17 hours and 57 minutes.

On the second day of our inspection, at 9.22am there were 50 patients designated as in the 'majors' area on the departmental computer system. For 27 of these it was noted that a DTA had been made and 41 of them had been in the department for more than four hours. One of the patients had been in A&E for 16 hours and 49 minutes. There was an expectation that patients with a DTA would eventually receive a bed. However, as the DTA time did not start until the receiving specialty team had accepted the patient, one patient was in the department for 17 hours but had not breached the government's 12 hour 'trolley wait' rule, which is aimed at controlling very long waits. There was a sense that targets rather than patients were the focus when dealing with long waits in the A&E.

We found that the reason for the delay in people with a DTA leaving the department was the poor availability of beds in the rest of the hospital. Without significant changes in processes in the rest of the hospital, there was a danger that the refurbishment of the ED would result in a nicer place for people to wait, rather than improving clinical care overall. A senior manager advised that the environment for patients was significantly better than this time last year, when patients would have been lined up in the corridor. Although significant improvements had taken place, it was not acceptable for patients to remain in the department for such lengthy periods. It was not possible to deliver the care patients needed in such an environment.

We spoke to senior managers about the issue of patients waiting in A&E for too long. They told us that things had

improved greatly since last year, but acknowledged there was still much more work to be done. They told us that it was a whole hospital issue because they were unable to find beds in the rest of the hospital. Two new wards were due to be opened in March and April which would increase the hospital's capacity by 52 beds. Senior managers also correctly pointed out that performance in the first two hours of attending A&E was better than the England average, and this would have more positive outcomes for those patients.

Vulnerable patients and capacity

The Alzheimer's Society has developed a 'This is me' document that is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It enables healthcare professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs. It can help to reduce distress for the person with dementia and their carer. It can also help to prevent issues with communication, or more serious conditions, such as malnutrition and dehydration. During our inspection none of the staff we spoke to were aware of this document and confirmed not tool or guidance was used for vulnerable patients.

Some people with learning disabilities carry a Health Passport that records medication and other key information about them, for example how they like to be treated. Some staff we spoke to were aware of Health Passports but some were not. None of the staff we spoke to were able to tell us who the learning disability lead in the hospital was or where they could go for advice.

Access to services

As part of our inspection we looked at how interpreting services were being made available to those patients who did not speak English as a first language. At the initial reception desk for people who walk into the A&E department, there was a specialist interpreter's telephone. We used the phone and were immediately put through to an interpreting service that stated they were available to find interpreters in a number of languages to assist people in the reception area.

However, it was not clear how people who arrived at the department in an ambulance would be able to access an interpreter. Staff we spoke to were unclear about how they would deal with such a patient who could speak little English. Some members of staff told us that there was a facility to call out an interpreter but none were able to say how it would actually happen. One senior nurse told us that as staff came from all backgrounds they could usually find a staff member to interpret. Another member of staff told us that she had been specifically told that she could not interpret for patients and a professional interpreter should be asked to attend. There was a great deal of uncertainty about the interpreting process, which could lead to a patient not being able to express their views.

Facilities for relatives

We looked at the relatives' room where people wait while their very seriously ill relatives are being cared for or where people are informed that a relative has passed away. We found it to be in a shabby condition with stained furniture and a five-inch-square hole in the wall. This poor environment can add to the emotional distress of a situation.

Leaving hospital

National data indicated that the percentage of patients who left A&E before being seen for treatment was very similar to the England average.

Many people were discharged home from the emergency department decision unit (EDDU). This was a unit for patients who may need only a short stay in hospital, for example for a period of observation by clinical staff or awaiting the results of tests. We observed that the unit had good processes in place to ensure the effective and timely discharge of patients, with occupational therapists available seven days a week. The department also had a good relationship with hospital and community social work teams to ensure that a full package of health and social care support was in place. Unfortunately, the unit was not able to function to its full capacity because it was also being used by patients who should have been admitted to the main hospital. These patients were staying for several days, meaning that more appropriate patients for the EDDU were having to stay in the main A&E department.

The trust performed much better than the England average on the previous six months' percentage of unplanned readmissions within seven days of attending the department. This may be an indicator that the trust, including A&E, was undertaking effective discharges and people did not need to attend again within a seven-day

period. People we spoke to were positive about the support they received during their discharge. For example, one person told us: "I am fine; they have sorted everything out for when I go home."

Learning from experiences, concerns and complaints

We spoke in detail to the senior management team about the complaints process and how they changed their practice to take into account patient concerns. Complaints are fully recorded and investigated by the department; however, some staff said that it can take much longer than it should for complaints to be investigated. Management and staff were all aware of the key themes of complaints from patients, namely poor communication and long waiting times.

The department was not proactive in obtaining the views of patients about the service they received. Patients were not aware of how they could feed back their views or make a complaint if they wished to. Although there was evidence that key themes were fed back to staff, this was not integrated into a process that checked whether people actually changed their behaviour as a result.

Are accident and emergency services well-led?

Requires improvement

Vision, strategy and risks

The department has made significant progress from its poor performance over the last few years. In particular, there have been improvements in clinical practice and waiting times in the last few months. Everyone we spoke to inside the department and from other parts of the hospital or from partner agencies told us that the service had improved.

We spoke to the senior management and clinical teams, and it was clear that they had shown strong leadership during these improvements. They had worked with staff to develop a clear vision of what improvement would look like. Over the last few months, there had been significant changes in both the physical design of the department and clinical processes. The department had been redesigned and the new assessment process introduced; this meant that the department was more effective and responsive to patient needs. From speaking to staff, we were aware that there had been some resistance to the changes and that staff had not always implemented new working practices, but it was clear that the management had the support of most of the staff. Now that the department had achieved some significant improvements, it was less clear what the next stage of improvement would be and how the momentum that had been achieved would be maintained.

The department had employed a part-time improvement consultant who had the role of staff development. The nursing sisters had a monthly meeting but there was no similar opportunity for more junior nurses to get together as a group to discuss their concerns and engage with each other and management. Middle-grade doctors described a vertical rather than a flat hierarchy, which could lead to communication problems. Senior management stated that they had an open-door policy for staff but there was a lack of robust processes in place for engaging with staff regarding their concerns and issues and communicating their vision for improvement.

Governance arrangements

There were clear lines of governance within the department on both the nursing and medical side. The senior management team displayed a corporate style and appeared mutually supportive of each other. Managers at all levels were able to describe issues of quality and performance, and how they were personally accountable for delivering them. However, it was less clear how improvements that were identified were put into practice, since there was no system of guidelines and most of the knowledge within the department rested with the senior doctors and nurses. This resulted in a lack of standardisation, and meant that junior members of staff had to rely on more senior members of staff for advice.

Leadership and culture

The trust's staff sickness absence rate was consistently below the England average between April 2011 and June 2013. In the department, nurse sickness was lower than the trust average but medical sickness rates were much higher. Senior managers were aware of this but did not have a plan in place to identify the root causes and reduce the absentee rate. We spoke to a number of junior doctors one of whom told us: "It's a good place to work. I feel very supported." Another said: "I used to work here before and it's much better than it used to be."

Accident and emergency

Staff we spoke with across the hospital told us that they were generally pleased with the support they received from their immediate managers but some spoke of a corporate culture of 'bullying'. Some members of staff were reluctant to speak to us or asked not to be named.

Patient experiences, staff involvement and engagement

The department had a poor response rate for the 'Friends and Family' test but had recently managed to increase this to 10% from 5%. Senior managers accepted that they needed to do much more to increase patient involvement and feedback. They had been looking at good practice from other trusts and were developing a plan.

Learning, improvement, innovation and sustainability

For the 2012/13 quality reports, trusts were required to report on participation/eligibility for 51 national clinical audits and confidential enquiries (selected by the Department of Health) that were conducted during that year. The trust took part in most of the audits and, in addition, the A&E department also took part in specific audits managed by the College of Emergency Medicine.

In May 2013, the trust invited the Emergency Care Intensive Support Team (ECIST) to undertake a review of the department. The ECIST team identified that the key issue related to patient flow within and from A&E. The team made a number of recommendations for improvement. The trust had implemented some of these recommendations and this had led to improved performance. The report noted that there appeared to be a lack of urgency from trust management about the need to achieve improvements in A&E. It was clear that the department would not be able to improve its performance further without commitment at the trust level to improve the flow of patients into beds on main wards.

The department showed some innovations. There was a consultant-led medical 'board handover' at 8am, 12 noon, 4pm and 10pm each day. This started with safety and then covered bed availability, infection control and target breaches, inpatient teams, internal professional standards, laboratory issues, porters, equipment and a check of quality.

With regards to medical training, the department used a simulation platform to test and develop their doctors' ability to respond to scenarios such as cardiac arrest within short timescales.

The rapid assessment system was also well developed in a form not seen in many trusts. These innovations showed that the ED team had the capability to make the progress required to improve clinical care across the department.

Inadequate

Medical care (including older people's care)

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

Information about the service

Acute medical services at the trust are provided across 11 permanent medical wards including a large Acute Medical Unit (AMU) which consisted of 76 beds. The total number of medical beds fluctuated (there was an escalation ward opened at the time of our inspection as well as multiple medical patients on surgical wards) but there are approximately 350 medical beds in total.

Over the course of the two-day announced inspection and further unannounced inspection, we visited all of the wards with medical patients on. We observed care, looked at patient records, and spoke with patients, relatives, and members of staff.

Summary of findings

The medical care of patients was too variable in its quality and safety. The high demand for beds led to patients being moved from ward to ward. The creation of temporary ward space was not always suitable to use for this purpose. This impacted on the ability of other departments such as cardiology to treat patients and cancellation of procedures was routine. There was a lack of permanent nursing staff on some wards, with mainly agency staff working. Overall ward staff numbers were low and patients care needs were not always being met. Patients were placed at risk of not receiving safe and appropriate care and treatment. There had been a recent increase in junior doctors and this had improved their availability at night and weekends. Although clinical engagement was improving in certain areas such as cardiology, this was not consistent throughout the directorate and this impacted on the ability for a learning and safety culture to be embedded throughout. Known problems were not resolved and action was not taken to protect the patient. There was a lack of ownership of the need to drive improvements and for the monitoring that it was achieved and sustained.

Medical patients were being moved numerous times and placed in surgical wards due to the capacity problems the hospital was facing. The short term improvements were not sustainable and presented concerns during the inspection due to agency staffing, lack of risk assessments and patients 'being lost' due to multiple moves delaying treatment and care.

Inadequate

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Safety and performance

Between July 2012 and June 2013 eight patient safety incidents reported that resulted in patient deaths attributable to the medical directorate; of these four related to the implementation of care and on-going monitoring. Three were found to be as a result of patient accident. There were 30 incidents that resulted in severe harm and 206 that resulted in moderate harm.

The trust was below the national average for new venous thromboembolisms (these are clots that form in the leg, and it is known that patients are at increased risk of developing them whilst in hospital) between November 2012 and June 2013. However we noted that in September there was an increase which led to the trust levels rising above the national average. We looked at how people were assessed for prophylaxis medication (an injection that has been shown to decrease the risk of developing a clot) during our inspection. The doctor who admitted the patient filled out a paper form (or in some cases a sticker) which was put in the patients notes. The ward clerk would then transfer than information onto a computer system. The trust had previously tried to get the junior doctors to fill the form in electronically but this had led to significantly decreased compliance and therefore they reverted to the old system. We looked in 25 sets of notes on the AMU and found only two sets of notes where the assessment was missing. In both of these notes a sticker had been placed noting the missing the VTE assessment. Although there was a 'tick box' on the sticker asking if an incident form had been completed in neither case had this been ticked. It should be noted that assessing the patient does not necessarily result in the prevention treatment being given as this needs to be written up separately on the paper drug chart. It was not clear whether the trust had audited whether their patients were receiving this appropriately

Between the months of February and May 2013 the trust had a significant increase in catheter use and new urinary tract infection (having a catheter increases patient's risk of urinary tract infections). However since then there has been a steady decrease and the levels in November 2013 were almost back to the national average. Whilst on our inspection we noted the trust had a catheter care pathway in their files, the majority of these were used appropriately.

Falls within the trust have been a concern and the trust has taken steps to reduce the number of falls. However, during the inspection the falls risk assessments were inconsistently being filled out resulting in an increased risk of falls for vulnerable patients that are not being identified.

The levels of reported Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections and clostridium –difficile infections were within expected for a trust of this size.

All of the medical wards we visited had safety information displayed on their walls. This included hand hygiene audit results, number of falls that month, and numbers of days without a pressure ulcer. This was updated on a daily basis.

Information we received from patients and relatives said that the wards and hospital had been dirty and unclean. Cleaning staff informed us they had been brought to the hospital from other locations to do a deep clean prior to our inspection. When visiting wards we saw that nursing staff were actively cleaning equipment and labelling it as cleaned. The majority of the labels viewed were dated for the days leading up to the announced inspection.

Staffing

Outside each ward there were notices to show how many trained nursing staff and healthcare assistants should be on duty and the actual number on duty. These showed for many wards the agreed staffing establishment was not achieved. Staff reported that they would also be frequently moved to different wards to work because staff shortfalls. For Division C there had been a drop in the vacancy rate from 13.6% to 8% for all medical and nursing staff.

The trust's daily ward safe staffing forecast tool, (which included the use of agency staff) records the number of beds per ward, the "safe" number of staff on each shift, the planned establishment for each shift and the actual number of staff scheduled to work from 12 February 2014 to 25 March 2014. The spreadsheet showed for some wards the planned establishment was below the "safe numbers". For example, ward 18, (a care of the elderly ward), the safe level was documented as four staff to work the early shift, four to work the late shift and three to work the night shift. However the planned establishment was for three staff on

each of these shifts. In addition the actual numbers of staff scheduled to work showed that throughout February and March 2014 the number of staff working often did not achieve the established numbers.

The use of agency staff was high on the majority of the medical wards. On the newly created escalation ward Snowdrop, only the ward sister was a permanent employee of the trust with all other staff working on the ward being agency staff. During the unannounced visit we found that overnight there were no members of staff working who regularly worked on the ward and they were unfamiliar with the ward surroundings. They told us that they had received handover and their induction to the trust from other agency nurses. This ward did not appear on the trust establishment data and ward safe staffing spreadsheets, so it was unclear how the trust were monitoring the staffing establishment of this ward.. There was a strong reliability on permanent staff to work additional shifts and we found staff to be distressed and emotional about the pressure being placed on them to cover shortfalls in staffing. Day beds were frequently opened to increase capacity and so allow further admissions which put further pressures on staffing levels.

We spoke to agency staff to understand what induction and skill checks were undertaken prior to them starting work on the medical wards. We were told by staff in charge that agency staff would have a 'passport' with them which would be checked on their arrival to the ward. However they were unable to produce these for us when we asked on the unannounced. The agency staff told us that they had been shown round the ward by the day team, but one of the agency staff was unable to show us where the crash trolley was. He acknowledged that he should know where it was and immediately went to locate it. We noted that agency staff where drawing up and giving intravenous medication despite having had no checks on their identity or proficiencies prior to starting.

Learning and improvement

The trust uses the Datix patient safety software system to report incidents. We spoke to staff at all levels (including nurses, ward clerks, junior doctors, and consultants) and asked them whether they used the system to report incidents. We were repeatedly told that they did not feel there was any point in doing this as they did not get feedback on individual issues of concern. Of concern, the junior doctors reported twice as many patient safety comments (11%) than the national average (5.2%) in the independent National Training Survey (NTS) commissioned by the GMC.

The number of incidents reported by each ward was not displayed in public view on all wards and ward staff were not able to tell us how many incidents their ward had reported in the previous month. In addition, although there were audits in place regarding falls, ward staff were not always aware of these. When reviewing patient's notes there was no evidence of risk assessments or care plans being completed in relation to falls.

Each division has a clinical governance board, which produces monthly summaries, and detailed quarterly reports. The Division Clinical Governance Board reports to the Division Board and to the Trust's Healthcare Governance Board. The divisional quarterly reports contained information which clearly identified issues and these also contained a list of actions and a general list for who was accountable for implementing them. There was no plan for how the implementation and what success would look like. The reports do not show how learning from these will be disseminated throughout the Division.

We saw that individuals on certain wards did take initiative as a result of incidents. For example, the matron on ward 6 explained that she was aware that the ward had had a significant number of falls. She instigated a root cause analysis to understand the time, place and cause of the falls. The results concluded that a significant number of the falls were related to independently mobile patients (51%) and specifically to alcohol dependent patients. This resulted in a successful application for an increase in staff on the ward. She also described the instigation of further audits on the ward and training of staff. However we were concerned that these examples were isolated rather than there being a genuine safety culture throughout the medical division.

Trust audits for Division C (within which medicine sits) records good standards of adherence to infection control protocols. We saw hand gel was available throughout the hospital and on the end of each patient's bed. However we observed a junior doctor being told by nursing staff that they were about to breach infection control protocols. The junior doctor did not accept this. The junior doctor was part of a medical team undertaking a ward round where

the consultant did not adhere to the bare below the elbows practice. Therefore staff were not putting learning into practice and were not being set good examples by their superiors.

Systems, processes and practices

Medical wards were not all maintained to a suitable standard that ensured the safety and well-being of the patient. On ward 17 the windows were leaking excessively and fabric towels had been used to try and contain the water. The windows were situated next to occupied patient beds. This placed the patient at risk of injury through slipping or tripping and being exposed to the elements. The ward records for reporting repairs required to estates showed this had first been reported six days earlier but no action had been taken. By the time we returned to the ward for the unannounced visit we found that part of the leak had been fixed, but heavy rain would still result in water leaking on the ward. There was an inconsistent approach for reporting the need for repairs to estates, some wards used a computerised system whilst others had a book and contacted the helpdesk. This inconsistency was reflected in how the work was prioritised, with some wards waiting weeks for repairs and other only days.

We found that fire doors were not always alarmed which resulted in staff breaking the seal on the doors to use a short cut across the hospital. This occurred on a regular basis. Once the seal had been broken there was often a delay in getting it repaired. This had been raised by the ward matron on multiple occasions, but no action had been taken to prevent staff from continuing to use the short cut.

The recent work being undertaken to improve some of the areas of the hospital has included changes to the flooring in the corridors. The specialist dementia advisor recommended that two colours were not used as it is seen as a barrier by people who have dementia. This advice was not followed and two colours have been used.

We had significant concerns relating to specific wards. Snowdrop ward was a recently created 'escalation' ward (so called as it was used to create extra bed space when the other wards were full). This area was previously the discharge lounge and the environment was not suitable to care for the patients admitted to this ward. There was an admission policy to the ward to ensure that only patients with low nursing and medical dependency were transferred there. However, this was not being adhered to, and on the unannounced visit we found that the form which should have been completed prior to transfer (which would demonstrate whether it was appropriate to transfer the patient to Snowdrop) was often being completed after the patient was transferred onto the ward. These demonstrated that there were numerous patients placed there who did not fit the criteria for the ward. We noted poor provision of equipment, medical stores and high numbers of agency staff meant this unit was not safe. Action was taken by the trust during the announced inspection to improve the stores and staffing levels. However our unannounced visit evidenced that this had not been fully addressed or sustained.

Some of the wards were very cramped, for example areas of AMU and Snowdrop. The space around the beds limited and restrictive. This would make it difficult for someone with a disability to safely access and use the area. This would also affect staff ability to use movement and handling equipment such as hoists safely.

The discharge lounge had been relocated because of the need to create the Snowdrop ward. The new location is situated at the end of a long corridor. Concerns were voiced about being able to safely move patients with reduced mobility in the event of a fire.

Deteriorating patients

The trust used a locally adapted early warning score system, known as the 'Early Detection of Deterioration system' (EDODs). On the reverse side of the scoring document was a flow chart indicating the relevant action to be taken by the person recording the patient's observations. This included speaking with the nurse in charge, calling a junior doctor, or alerting the Critical Care Outreach (CCOT) if appropriate. The outreach team were available twenty four hours a day, seven days a week. During an unannounced visit we noted that in the majority of cases these were not being escalated as per the scoring system outlined on the early warning system. This inconsistency may result in deteriorating patients not being treated in a timely manner.

We interviewed the Resuscitation officer who informed us that following the trusts involvement with the National Cardiac Arrest Audit work had begun to retrospectively look at the notes of patients who had undergone a cardiac arrest. This aimed to identify whether the patients deterioration could have been recognised and escalated earlier, thus preventing the cardiac arrest. The group

included a junior doctor (who had been involved in a similar practice at the trust they were at previously) as well as a medical and ITU consultant. Although it was too early for them to have detect specific patterns (i.e. time of day or particular wards), she was in the process of analysing the data in order to present back to the frontline staff.

Handover

Whilst on the unannounced inspection we observed a junior doctor handover. These took place at 9pm every evening and allowed for the day on call team to hand over the night team. This was found to be an informal handover, without a specific start or finish time. There was no attendance record and began as soon as certain team members arrived rather than waiting for the whole team to arrive. It was not structured and it was not clear what information was expected to be handed over and what wasn't. The trust does not yet operate a hospital at night system. Neither the CCOT nor a representative from the site team attended.

We also observed the nursing handover. Staff were provided with a computer printout that provided a brief outline of each patient's diagnosis, history, nursing plan and doctor plan. Verbal handover took place at the end of each bed and for very sensitive or confidential information this took place in a room. However, it was possible for patients on the ward to hear and know what was happening to other patients. Despite the handover form which recorded if a patient was for DNACPR, when speaking with agency staff they were not aware of this.

Monitoring safety and responding to risk

Patient's case notes were tracked on one ward (Snowdrop) to assess the effectiveness of the care being delivered. The agency nurse caring for the patient had taken handover, but this failed to show all of the patients care needs. The agency nurse was working alone and had not read the care plan or notes and this impacted on care delivery. The patient had grade 4 tissue damage acquired in community. They had been assessed by the Tissue Viability Nurse who had documented their plan of care in the patient's notes. This had not been transferred to the care plan. Therefore the agency nurse was not aware of agreed treatment plan for the skin. The patient was on an airflow mattress which had been incorrectly set up, the patient weighed 50.4kg but the bed was set up for a patient weighing 160kg, this incorrect use of equipment could cause increased damage to the skin. The patient also had raised sodium and was to have their fluid intake and output monitored closely. Once IV fluids had been discontinued, the fluid charts recorded significant drop in fluid intake, a total of 650mls a day. Their drink was placed out of their reach and there were insufficient knowledgeable staff working to care safely for this patient.

The trust used the waterlow assessment tool for monitoring patient's level of risk for developing pressure damage to their skin. The majority of the assessments reviewed, were not completed correctly, with the score being lower than it should be, therefore indicating a reduced level of risk. The impact on the patient was this limited their access to the appropriate pressure relieving equipment. Also the score would also be used in the MUST tool for screening nutritional status and so the results of this would be incorrect. This the impacted on the patients access to clinical specialists such as dieticians and tissue viability team as well as placing them at increased risk of harm. The tissue viability team taught the completion of the waterlow during staff induction, but this was not renewed at any time. The Trust had not audited the use of the assessment tool as part of their actions for responding to the rise in the number of pressure ulcers.

Patient flow and bed capacity issues have been identified as risks by the trust. There has been the introduction of daily bed capacity meetings. However this seems to results in the inappropriate movement of patients for non-medical reasons. Medical governance has been recognised as a risk both by the division and the trust, which means recognition of risks, investigations and associated learning is not being done.

Anticipation and planning

The trust wide strategy for improving quality was drafted before the October 2013 inspection and has not been updated since. Also, an action plan was produced in response to our last inspection although this did not adequately address the concerns identified. There was little or no evidence to show that there was any anticipation of potential risks at trust level. The trust was not proactive in its approach and did not use the information and resources it had to identify trends and themes to develop a strategy to cope with possible complications or events that may occur. Any actions taken

were to resolve the short term problem, with no anticipation of what may be needed in the future or include consideration of possible external influences on the horizon.

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

Requires improvement

Using evidence-based guidance

We did not see evidence that national or local guidelines were being used regularly. There was a large binder of 'Clinical Guidelines' in the doctor's office but this was dated 2011-2012 and did not appear to be used regularly. The trust told us that the guidelines were available on the intranet, although as we have stated elsewhere over 25% of these were not in date. Staff also had access to the 'UpToDate' information system (which is an evidence-based clinical decision support system).

We looked at 20 sets of medical notes on the AMU and noted that there were no pathways or proformas in use for common conditions such as Community acquired pneumonia, sepsis or acute coronary syndrome.

One patient who had been diagnosed with pneumonia (with a CURB score of 3 indicating it was severe) had not had a chest x-ray despite having been admitted for over 6 hours. Two patients whose admitting diagnosis was sepsis appeared to have significant delay in receiving their first dose of antibiotics. One patient was found not to have received this until they were seen on the post take ward round by the consultant which was over 11 hours after they were admitted. This was despite them being pyrexial, more confused and tachycardic (fast heart rate) on admission (indicating the infection was more severe). There is good evidence that early appropriate use of antibiotic improves patient outcome with sepsis. Patients with a confirmed NSTEMI (non ST elevation myocardial infarction, a type of heart attack) were still on the AMU 48 hours after admission, as there was not a bed available on the Coronary Care Unit.

We found that there were trust antibiotic guidelines available on the intranet. This explained which antibiotics should be used for specific infections. However when we looked in medical notes and patient drug charts we found that these were not regularly followed. We noted that drug charts did not often have the indication for the antibiotic or the prescribed length of duration documented. In some cases the ward pharmacist had added this detail to the drug chart but this was not widespread practice. Appropriate antibiotic use is important to prevent anti-microbial resistance and antibiotic related infections such as clostridium difficile.

There were no ambulatory care pathways in use, although we were told that these were in development. This meant that some patients were being admitted for certain conditions (for example deep vein thrombosis) that in other trusts would be treated on an outpatient basis. This impacted on patients by exposing them to risk of hospital acquired infections as well as the overall bed capacity for the trust.

Performance, monitoring and improvement of outcomes

The hospital also participates in the Myocardial Ischaemia National Audit Project (MINAP), and it offers a Primary Coronary Intervention (PCI) service. The trust scored well in the percentage of patients receiving intervention within 90 minutes (good practice) with 92.9% of patients receiving it within this time in comparison to 91.7% nationally. Its median 'door to balloon' time is 26 minutes which is again better than the national medical (40minutes). According to the 2013 audit results 97.7% of patients presenting with a Non-ST Elevation Myocardial Infarction (N-STEMI – a type of heart attack that doesn't benefit from immediate intervention) saw a cardiologist on their admission and the same percentage were admitted to a cardiology ward. Both of these are good practiCe and above the national average.

There was a central audit office, which co-ordinates and supports audit in the Trust. The office produces a forward audit plan each year. This year the central plan was being produced in combination with the divisions, last year it was produced centrally and the divisions asked to follow it. The programme was mainly composed of national audits, but was starting to be supplemented by local and trust wide audits. The latest trust wide audit was into the quality of patient documentation particularly focusing on legibility and coherence of patient notes.

The Trust's documentation audit found that 86% of Division C records audited by the trust did not document the daily review in patient's notes. This percentage for Division C increases to 90% when looking solely at the

weekend daily reviews. A further 46% of patient notes in Division C did not record the clinicians contact details. Given the practice to place medical patients wherever there is a bed available, or to create bed capacity, coupled with the high use of agency staff and the pattern of repeatedly moving patients around, the quality of the record keeping is essential for all of those caring for patients to ensure that they receive the appropriate care and treatment. This audit demonstrates that patients could be placed at risk.

Staff, equipment and facilities

The governance records show that 81% of training had been completed against a target of 80%. This had been an increase from 69% in the last quarter. Additional training was provided such as dementia by in house leads. However feedback was that due to lack of time the new skills staff learned during the training could not be implemented. Some staff felt pressurised to undertake levels of responsibility they felt they were not ready for and when they voiced their concerns this was not responded to.

The trust had recently significantly increased the number of junior doctors at senior house officer level. It had done this by employing doctors who had trained overseas as clinical fellows. We spoke with these doctors and were told that they were encouraged to attend the same amount of training as the doctors employed by the Local Education Training Board (LETB). They all had named clinical supervisors and the trust had paid for them to have e-portfolios. (This is an electronic record of procedures and competencies gained whilst training).

As a result of the trust's recruitment drive they had been able to increase the number of junior doctors on the on-call rota, in particular between the hours of 3pm and 12am when it was very busy. We were told by every junior doctor we spoke with that this had significantly improved the experience of being on call and meant that patients did not have to wait as long to be seen.

There was a variety of equipment available for wards to access from the equipment library. However, the promptness in which wards received this varied, with some wards receiving a pressure relieving mattress within a few hours and others waiting days. The trust criteria for the allocation of such equipment was that if the patients waterlow score was over 20 then they should be on a pressure relieving mattress, however we noted that one patient with a waterlow of 23 had been waiting three days for one. Other staff reported that they had been able to order new equipment such as medication trolleys and commodes and had received these within a few weeks.

Multidisciplinary working and support

The trust used multi-disciplinary documentation for all those involved in the care and treatment of a patient to record their actions in. This was kept separate from where the doctors wrote and we found that this had led to miscommunication between the groups resulting in delayed discharges. In addition, there was a concern that not all of these services were being accessed when patients needed them. This could be as a result of inaccurate assessments, or a failure to recognise the need for the referral. One patient had significant weight loss in a short period, (over 3Kg in 18 days) yet there was no referral made to the dietician. This was particularly evident on the escalation ward – Snowdrop where we noted that one patient had been waiting 12 days to see a physiotherapist and another patient waited 13 days. This was raised at the site meeting we attended and we were informed by the trust executive team that there was a trust wide shortage of some of the allied health professionals.

The AMU had daily meetings (during the week) at 12pm where every patient was discussed. Doctors, nurses, and AHP's attended these meetings.

Patients admitted with problems associated with their alcohol dependency were seen on the AMU by a dedicated team. The trust also had an acute oncology team who cared for patients admitted with a known diagnosis of cancer. We saw evidence in patient's notes that patients were being seen promptly after their admission by both of these teams.

Are medical care services caring?

Requires improvement

Compassion, dignity and empathy

In the 2012 CQC inpatient survey the trust scored below the national average in 8 out of the 10 areas of questioning. Questions in which the trust performed worse than other trusts included 'Overall did you feel you were treated with respect and dignity whilst you were in hospital and 'overall impression of stay'.

Inadequate

Medical care (including older people's care)

The Friends and Family Tests had been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust has scored below the national average for three out of the four months since it was introduced in the inpatient scores. Within the trust, 11 out of the 12 wards scoring below the trust average were medical wards.

Comments and reviews received via NHS choices were mixed, some praising excellent care, respect, dignity, and kindness to patients, while others flagged humiliation and degradation of patients and the attitude of staff as a concern.

During our inspection we also witnessed varying degrees of compassion and empathetic care. For example, whilst we observed the healthcare assistants to be kind and attentive when supporting and caring for patients we also heard some staff refer to the patients not by name but by bed number or diagnosis. Staff seemed to have become accustomed to patients being exposed and did not attempt to conceal their nudity unless it was brought to their attention. We witnessed in some of the consultant led ward rounds discussions about patients diagnosis would occur in front of the patient and relative prior to the team introducing themselves. Some of the wards were incredibly busy and noisy, and staff did not appear to acknowledge the patients that they might find this disconcerting.

People told us that patients could be left for most of the day without being taken to the toilet or left sitting with only thin night clothes on and not being given blankets. People also said patients were left with food placed in front of them with no help to eat or drink. We observed a meal time and saw that the red tray system was in use, which identified patients who needed additional support with eating. However the information in the kitchen was out of date and we saw that the patients who were being supported to eat did not actually have red trays. In addition staff reported there were issues with the contract for housekeeping, in that kitchen supplies such as hot chocolate were not maintained, and some housekeeping staff but not all were impatient with people when taking the orders from the menu.

Patient records and observations showed the most vulnerable patients were not always receiving basic care. Those requiring support with mouth care received this inconsistently, with long periods of time when this care was not provided. Patients who were at risk of dehydration and needed encouragement and support to drink were not provided with the assistance they needed. Fluid charts showed some patients on some of the medical wards visited were not having a good basic level of fluid intake.

Involvement in care and decision making

Since May 2013 two applications have been made under the deprivation of liberty safeguards (DoLS), one was granted and the other was declined. One patient's files showed that they had several mental capacity assessment completed. These showed they were used appropriately to assess the person ability to make decisions about specific matters. The notes also record that a best interests meeting was held with the family and the multi –disciplinary team. However we found that this was not a consistent picture across medicine as this was the only example of good practice evidenced regarding decision making when someone lacked capacity. Other records viewed showed that best interest meetings had not been conducted or were done inappropriately.

There was a varied picture, which was not restricted to particular wards, about how much patients and their relatives were involved and consulted about their care and treatment. Many patients said they did not know what was happening. Some reported that they had waited so long to get results that the person who was meant to tell them had finished for the day and gone home. A few patients said they said they were kept aware of their treatment and found staff communicated updates with them at each stage.

Trust and communication

The Trust documentation audit found that Division C had a high failure rate to record their discussions with patients and relatives. Friends and family survey completion was below the trust target (15%) in the medical areas. Of the formal complaints made to the trust these consistently included a significant percentage (13-15%) relating to poor communication.

Patient feedback was varied but a significant number of patients and relatives have said that communication by the medical staff was poor, with patients often not knowing the results of tests, despite asking and have not had things explained to them.

Emotional support

The trust had chaplaincy which was multicultural and this could be accessed to provide emotional and spiritual

support for the patient and families. The trust operated visiting times and adheres to these. A family wanted to visit with a young grandchild of a patient, the ward matron said they do not allow young children on the ward but would allow them in for a few minutes. No reason was given why a young child could not visit. The trust website says "A responsible adult should accompany all children visitors; those under the age of 12 are only allowed to visit with permission from the nurse in charge." But no reason is given. The trust also had protected rest periods & meal times, to allow the doctors and nurses to carry out patient care, and for essential cleaning to take place, according to the website. However families reported that if they did not stay and support their relative to eat they would not get the help they needed.

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

Inadequate

Meeting people's needs

The trust's main focus has been the creation of additional bed capacity at short notice to enable them to continue to admit patients. This impacted on the delivery of care to the patient. The Trust runs with a very high bed occupancy rate with medical beds running in excess of 95% in October 2013. This frequently meant patients were not place on the most appropriate ward to meet their medical and nursing needs. Medical ward rounds could be protracted due to the time spent locating the patients spread out across the 12 medical wards and those placed in day case beds. Although there were systems in place (the Real Time computer system, designated 'buddy wards' and a printed outlier sheet distributed to teams every morning), on the unannounced inspection we found that one patient was not seen for five days following their transfer to the escalation ward (Snowdrop). A clinician had documented an apology in the notes, stating that they had not realised the patient had been transferred to another ward still under their care. This also impacted on other services within the trust such as phlebotomy staff. Staff, patients, and relatives reported how patients were frequently moved not only within the ward but also to other wards, often in the middle of the night. For the elderly frail patient this was disorientating and for those with dementia it would increase their distress and anxiety. One patient who had dementia believed they were not liked as they had been moved six times in eight days, and so were upset and distressed.

Patients and staff expressed the view that the Trust policy to move patients to create bed space at any time of the day or night caused a lot of distress. The patient could become disorientated and the relatives reported that they were not informed and no one could tell them where their relative has been moved to. The culture of the senior management no longer viewed patients as people but only recognised the need to create bed space

We attended a site meeting on our unannounced inspection and discussed the bed capacity with the operations team. They acknowledged that the trust had been in 'Red' for the past months and as such staff such as consultants had become desensitised to the escalation plan. Although there was a standard operating procedure in place for the different alert statuses, compliance with the action required from different members and groups of staff was not monitored. Whilst on red alert, a daily senior review of patients should have been undertaken. We did not see evidence of this, the site team were unable to assure us (or themselves) that these were being undertaken and staff did not appear to consider the current bed status as unusual or worthy of increased diligence with regards to discharging patients.

The executive team told us on multiple occasions that in response to the bed capacity they were planning on opening more beds in two new wards. We were not informed what arrangements were in place to ensure that these would be adequately staffed by nursing or medical professionals. There was little evidence of any action to increase admission avoidance or reduce length of stay within the medical directorate.

Vulnerable patients and capacity

Within the trust governance papers there was no reference of how it planned to support patients with learning disabilities or physical disabilities, although they had recognised they lacked trained staff in learning disabilities. There was a dementia specialist appointed who was working to raise awareness and have people's needs taken into consideration, with changes being made to the

environment. However they reported this advice was not followed. There was no evidence of information leaflets being provided in easy read formats or the pictorial menus being made available.

The hospital was situated within a community which was multi-cultural, with over many different languages being spoken. There were translators available to enable the patient to communication safely about their treatment. However there was a significant reliance on the Trusts own staff at all levels to act as interpreters. Staff also said that relatives were used to communicate with the patient. For those patients with limited or no verbal communication there were no aids provided to support them to express their views and understanding, for example picture boards. Ward staff said there was meant to be a pictorial menu available but they had never seen it. This lack of alternative systems to communicate or failure to ensure an impartial interpreter was used placed patients at risk. The risk of not having their personal preferences taken into account or ensuring they are giving informed consent.

Access to services

The constant use of day bed to care for patients who have been admitted as an emergency has had a direct impact on those awaiting elective admissions or procedures. The cardiac service was having problems on a regular basis, cancelling cases. In addition, the radiology departments' lack of resourcing impacted on the patient flow throughout the hospital and their patient experience. Cancellation of procedures and appointments is a routine event in the hospital.

Cardiology

Patients presenting with an ST-elevation myocardial infarction (heart attack) within working hours would be transferred to the catheter lab. Out of hours, they would be transferred to a nearby cardiac unit. There were no clear pathways for the hospital to treat N-STEMI, some patients go to CCU some to AMU. A significant number of non-cardiac patients are also placed on CCU. Having said this, as previously mentioned, the trust is performing above the national average for the percentage of N-STEMI patients transferred to a cardiology ward.

At the time of the inspection the angiography service ran seven days a week. However as the angiography ward was being used as an escalation ward, that 90% of elective patients were cancelled. The day beds in the cardiac catheter laboratory were not equipped for patients to stay overnight and patients were looked after in this area by agency staff overnight. There have been four Cardiac catheter laboratory managers in two years, with no manager in post at the time of the inspection.

Radiology

The lack of sufficient radiology services and staff were a significant contributor to slow patient turn around in the hospital. The radiology resources and department had changed little over the last ten years and staff reported previous clinical leadership was poor. The repercussions were felt throughout the hospital as a result, and deficiencies in this service were very noticeable. The radiologists were unable to cover for each other as they had no spare capacity, which impacted on all clinics. This had resulted in the loss of entire clinics as a result. Patients and medical staff experienced delays in investigations and reporting which impacted on the length of the patient stay, diagnosis and the bed occupancy. Worryingly they had not been identified as a risk by the Trust or the Division. The aim of the department was to complete a radiography report within three days; however the average length of waiting for a report had increased from 4.5 days to 14.5 days (Division B quarterly quality report). After five days any unreported films went to an on line reporting agency with an aim to report all films with 7 days. Many of these reports were sent to the agency. There had been no consideration given to prioritise high risk cases, for example to send those report directly to the agency. There is no plan to increase the resourcing of the radiology department.

A SIRI in October 2013 in ITU involved the interpretation of head CT scans which may have contributed to a delay in diagnosis and treatment. The results of this investigation have been presented to the SIRI Final Review Panel on the 21 November 2013.

Leaving hospital

The process for planning a patients discharge varied from ward to ward within Division C. In general, patient discharge plans do not start to be made until they have been deemed medically fit and patients reported not being involved in the planning, only finding out that they were leaving at very short notice, the day before or same day. During the inspection we noted patients spent a long time in the discharge lounge. The main cause of delay was due to waiting for pharmacy to dispense medication to take home. An action that has been implemented in response to this was to allow the patient to leave and send the

medication in a taxi to the patient's home. There continued to be incidents were patients were discharged home after 8pm. Staff believed that successful discharge processes were affected by a lack of effective communication with the four local authorities. There was no consistent approach for the discharge of patients, on some wards it was medically lead, other led by the discharge team or the lead matron. The constant demand for beds was often the drive to discharge patients.

There was an on-site social services team who patients were referred to when they were ready for discharge home and may need additional support or to move to residential care. The trust has recently joined up with Berkshire Healthcare NHS foundation trust to introduced Post Acute Care Enablement (PACE). This service offers medically stable patients the opportunity to be cared for either at home or in a community bed, with the provision of integrated acute, community and social care.

Learning from experiences, concerns and complaints

Division C received 77 formal complaints/concerns in the last quarter. The main themes were poor communication with patients on discharge, standard of nursing care and bed moves, especially out of hours.

According to the governance report the previous complaints had resulted in action being taken within the division. There was no supporting information within the report to evidence that these changes had taken place or what was being done to assess their level of impact on resolving the issues complained about. The trust report they are slow to respond to complaints with a response target set at 10 days, but actually achieving 18 days.

The majority of the issues raised in complaints have not been resolved as they have been evidenced during this inspection. This shows there is little or no learning from the concerns raised by patients. Staff reported that they did not receive feedback from incidents they reported and so were not aware of the outcome or planned lessons to be learned.

As a result of the DoLS applications made a training session took place with the Local Authority, this was reported to have been useful and therefore further training has been arranged. This demonstrates the recognition of the need to improve understanding and application of DoLS and that action was taken to enhance the staffs knowledge and skills.

Are medical care services well-led?

Requires improvement

Leadership and culture

A significant amount of work had gone into developing the senior nurse leadership at ward level, and we met with engaged nurses who were passionate about the quality of care that they were providing. However the culture and leadership varied from ward to ward and it was evident that the significant use of agency staff stymied the ability in some cases of developing a cohesive and effective team. There was a lack of accountability towards patients, which had the potential to impact on patient care.

Staff spoke of being supported by their line manager but more senior management culture and behaviour was to bully and pressurise staff. Staff felt that they could not escalate concerns and were not confident that if they did they reached the appropriate sector. Staff were stressed and worried about their professional accountability given the circumstances they were working in. Although staff sickness was below the national average, some staff had needed to take time off work due to the stress.

Vision, strategy and risks

There did not appear to be a vision for the division or a clear strategy for all staff to strive towards. The future of the trust was consistently used as the rationale for lack of clarity regarding a clear strategy or vision. There was no evidence seen of long term planning, rather a more short term response to manage the day to day issues arising, such as bed management. Senior staff explained that work had started to resolve some of the concerns identified through previous CQC inspections, this work was at an early stage and would need to be developed further

There appeared to be a good relationship between the divisional clinical lead and the divisional manager, though at consultant level clinical engagement was inconsistent, and this was having an impact on their ability to function as a directorate and to embed a learning and safety culture. It was evident that recent progress had been made in some

areas such as cardiology, but that this was not widespread. Specific areas of concerned had been highlighted by a recent Joint Advisory Group (JAG) visit to the gastroenterology department, which deferred their decision to award accreditation of their endoscopy unit. Reasons for this included concerns over the clinical leadership. A 'them and us' culture existed in many cases between clinicians and management – with clinicians feeling that the management team consistently moved on after a few years (or less) resulting in them feeling like there was little point in working with them as they would soon be replaced.

Governance arrangements

The divisional management team was relatively new in position and we were told that clinical governance was a work in progress. We were informed that this was a high priority for the team but they admitted that their processes were still in their infancy. Each division had a clinical governance board, which produced monthly summaries, and detailed quarterly reports. The Division Clinical Governance Board reports to the Division Board and also to the Trust Healthcare Governance Board.

Mortality and morbidity meetings were not common practice in the medical division, although work had begun to analyse notes of patients undergoing a cardiac arrest to ascertain if their deterioration could have been escalated earlier, and whether in doing so would have affected the outcome for patients. Again this work was being undertaken by a few individuals, rather than it being an expectation that beneficial learning should be undertaken by all to improve patient care.

Patient experiences, staff involvement and engagement

There was little or no evidence of patient involvement in driving the trust forward. The family and friends survey had a poor uptake, and the trust responded to complaints slowly. Patients report that their experience of communication was poor and they do not get a response to their concerns/complaints. There was no evidence within the governance papers that shows how they engage with the public or plan to do so in the future.

Inadequate

Surgery

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

Information about the service

The acute surgery division at Wexham Park Hospital had five surgical wards, a surgical admissions unit, and nine operating theatres. The hospital provided elective and emergency surgery in a range of specialties including trauma, orthopaedic, urology, gynaecology, and ear, nose and throat (ENT), as well as general surgery. The emergency theatre provided a 24-hour service.

We visited all five of the hospital's surgical admission wards, including trauma, orthopaedics, urology, emergency surgery, and the surgical assessment unit. We also visited the hospital's main theatre suite and the day surgery unit.

We talked with 18 patients, two relatives, and 65 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, therapists, and managers. We observed care and treatment and looked at 22 sets of patient records, including medical and nursing notes. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

While there were many aspects of surgical care that were safe, some areas required improvement. These included completion of the World Health Organisation's (WHO) surgical safety checklist, improving staffing levels, and learning from incidents. There were concerns about the use of the theatre recovery area as a bedded area for patients.

Data from national audits and databases showed that surgical outcomes were at or close to the national average. We found that many of the staff we spoke with were compassionate and caring but they felt that workload pressures did not always give them sufficient time to spend with patients. Many patients spoke highly of surgical and ward staff although there were some exceptions. Patients often felt that staff were responsive to their needs but that the hospital's systems and processes were not.

Key examples of the hospital's lack of responsiveness included the high number of cancelled or delayed surgical operations at short notice and the frequency with which patients were moved from one ward to another. There was a large volume of outliers (medical patients) on almost every surgical ward, which meant that many patients lacked continuity of care because they were being moved to different wards. Arrangements for admitting women to ward 20 (a ward for gynaecology and women's health), particularly those who miscarried, were inappropriate.

Although individual inpatient surgical admission wards were well-led the hospital's surgical division as a whole was not. Surgical staff told us there was a culture of

bullying and staff were discouraged from raising concerns. When staff raised concerns or suggested improvements, they said these were ignored. Governance arrangements were poor. There were inadequate systems for monitoring the performance of surgeons. Managers were slow to implement changes as a result of incidents and never events (which is a nationally defined largely preventable patient safety incident).

Are surgery services safe?

Inadequate

Safety and performance

Wexham Park Hospital reported two never events relating to surgery in the last 14 months. Never events are serious patient safety incidents that should not occur if appropriate preventative measures are taken. The trust's investigation of the never events found that the WHO safety checklist (designed to prevent avoidable harm occurring during surgery) had not been fully completed in one of the cases. The findings indicated that if the checklist had been completed, the never event would not have happened.

Trust audits of the WHO checklist have also consistently identified significant gaps in the completion of the checklist but little action has been taken in response. An audit from February 2011 identified high levels of non-compliance with the WHO checklist. A further audit in July 2011 found compliance with the checklist had improved but there remained significant non-compliance in some areas. A further audit of compliance with the 'five steps to safer surgery' procedures in January 2014 found serious lapses in surgical safety procedures. Concerns were identified both around the completion of the WHO surgical safety checklist and about the quality of the checks that were done. The audit found there was no team briefing in 69% of cases checked; in 59% of cases where there were team briefings, not all members of the surgical team were listening to the information discussed; and sign-out was completed 69% of the time. The audit also found that, even though the WHO checklist was completed, it was not always completed appropriately. For example, in 73% of the cases checked, the WHO surgical safety checklist was not completed before patients left theatre. This meant the checklists were often completed retrospectively when they should have been completed right before and immediately after patients' surgery.

Staff told us that some surgical staff did not understand the value of using the surgical safety checklist and therefore, refused to participate in some of the required checks.

Overall standards of cleanliness in theatre and in the wards we visited were good. Housekeeping standards and cleanliness were regularly audited. Audits showed high levels of compliance with performance measures. Staff told

us the hospital had recently undergone a deep clean and cleaning arrangements were improved. Patients we spoke with praised the cleanliness of the hospital and many commented that cleaning standards had improved considerably in the last couple of months. The cleanliness of equipment and trolleys was also much improved. New trolleys that could be cleaned easily were in use. Store cupboards, treatment rooms, and sluice rooms were tidy although the bins in the sluice room on ward 2 did not meet infection control standards. Hand hygiene gel was available at the entrance to every ward, along corridors and at the bottom of each patient's bed. Staff and visitors were encouraged to use alcohol gel and there were large signs educating people on the importance of using hand gel. Infection rates (August 2012 – July 2013) were similar to those of other trusts for methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections.

Learning and improvement

Many of the main theatre and recovery staff we spoke with were keen to learn from incidents and to make improvements in their own practice. Staff in recovery gave us an example of an initiative they had implemented in order to improve patient safety. Recovery staff in theatres found that ward staff did not know how to use the same type of breathing equipment as they did. As a result, theatre staff now use a different kind of breathing equipment when moving patients from recovery onto a ward. Ward staff found this equipment much easier to use because they were already familiar with it.

However, almost all the staff we spoke with in theatres told us they did not feel they worked in an environment that encouraged learning and improvement. They said when serious incidents and never events were reported, they were investigated, but they were not always investigated promptly. Staff felt changes were often slow to be introduced and were concerned about the impact this had on patient safety. When changes were made, they were not always communicated from managers to staff. Changes in protocols and systems were not always monitored to ensure that learning was embedded and improvements were achieved. Results of audits were not always communicated to them. When we asked theatre and recovery staff whether they had feedback on the results of the WHO audit conducted in January 2014, they were unaware there had been an audit.

Staff we spoke with were able to describe when they would report an incident and how they would so. Staff who were involved in incidents told us they were given individual feedback about the incident and any areas where they could improve were discussed with them.

Systems, processes and practices

There were systems in place to ensure that care was delivered consistently and safely, although they were not always followed in practice. Risk assessments for falls, dementia, and venous thromboembolism were undertaken but not all of the time, and we found evidence of this in the patient records we saw). Where observations were required, patient records showed these were done at the required frequency. The hospital used a system called 'intentional rounding' to monitor patients and ensure that required care was provided. This system was in use on the surgical wards we visited. Patient records we checked showed intentional rounding was usually carried out with the required frequency that had been agreed for each individual patient.

Patient records showed care was planned and provided by multidisciplinary clinical teams. The nursing notes we saw were legible and were almost always dated, timed and signed in line with guidelines from the Nursing and Midwifery Council. However, patient records were not always well maintained or kept secure. Patient records from the day surgery unit were especially poor and were left unsecured for long periods. On the day we visited the day surgery unit, there were nine patients, eight of whom had surgery, and only one patient had a falls risk assessment. Other risk assessments were not always done and varied in quality. The quality of care plans across wards was inconsistent and they did not always include adequate information about how patients' needs were expected to be met. Ward staff told us they did not always have time to write or update care plans. Where risks were identified, there were often no care plans to show how the risks were addressed.

Equipment

On one of our visits to theatre, we were told that the packaging for all three of the theatre sets that were intended for use that morning was damaged. Sets include surgical instruments and equipment that have been sent to the sterilisation services unit and returned to theatre for use. The sets could not be used because there was a risk the sets were no longer sterile. Staff told us they regularly

received sets whose packaging was compromised. The repeated damage to sets had resulted in delayed and cancelled operations. Staff told us they raised concerns about damaged sets but these had not been addressed.

The risk assurance framework for theatre identified a number of risks in relation to either old equipment or insufficient quantities of equipment. These risks were identified in September and December 2012 and, according to the risk assurance framework, were not resolved. The risk assurance framework showed equipment shortages were sometimes being dealt with by "borrowing from [another] speciality". Staff we spoke with raised concerns about the age of some of the equipment in theatre. They told us equipment was not regularly serviced and there was no planned preventative maintenance for some of the equipment they used.

Some of the daily checks on resuscitation equipment were not always done on the hospital's surgical wards. The trust's nursing and midwifery dashboard showed poor compliance with checks on crash trolleys and resuscitation equipment on some wards. Matrons on these wards were aware of the need to improve in this area and there were arrangements to re-audit compliance. Staff in theatre told us they usually had the equipment they needed when they needed it. However, staff on the surgical wards told us there was sometimes a shortage of basic equipment such as linen and pillowcases, clothing for larger-sized patients, aprons, and gloves. . They told us that when basic supplies were not available, they 'borrowed' from other wards. We observed that there were sufficient pillows on the wards we visited to meet patients' needs, although staff told us the pillows had only recently arrived.

Staffing and handovers

We observed a number of nursing handovers between shifts. There was good communication about each patient's needs and discussion about key risks. When we spoke to individual nurses about patients in their care, they demonstrated good knowledge of patients' needs and how these needs would be met. There was a protocol in place for identifying deteriorating patients and seeking medical help. Staff we spoke with understood these protocols.

We looked at staffing rotas and found there were regular staff shortages in a number of areas. Staff on wards 1, 2, and 3 told us they were frequently short of nurses. They said this was partly because of staff being on sick leave or maternity leave but also because staff from one ward were often 'pinched' to work on another. Ward staff said they were allowed to use bank and agency staff to fill vacancies but in reality it was often difficult to get agency or bank staff. There was a high number of junior nurses on ward 2, which sometimes affected the timeliness with which care was given. For example, there was sometimes only one nurse on the ward who was trained to give intravenous medicines. Staff sometimes worked additional hours and matrons often used their managerial time to help staff care for patients. We found some staff came in to work even when they should have been on annual leave. They told us they needed time to 'catch up' with their paperwork. Most of the patients we spoke with spoke very highly of the nurses and healthcare assistants who looked after them but commented that staff were always very busy and worked long hours.

Staffing levels on ward 20 were more consistent but there were a high number of staff on sick leave or maternity leave, which meant the ward relied heavily on agency and bank staff who were not familiar with the ward and who did not know the patients on the ward.

In the theatre recovery area, staff told us they did not have sufficient numbers of staff to meet the needs of patients in recovery. They said this was because staffing levels were not adjusted to take into account the additional work involved in having to discharge patients from recovery. As a result of capacity problems within the hospital, patients often had to be looked after in or discharged from recovery beds. This meant recovery nurses were responsible for carrying out activities that would not normally take place in recovery, for example making tea and sandwiches for patients or helping them to use the toilet. These additional responsibilities put staff under constant pressure to balance the needs of post-operative patients who needed to be recovered with those of other patients in recovery. We observed this during our visits to recovery. We found recovery was a pressured environment with very stressed staff, who, despite the pressures, worked well together.

We found that when recovery was full, patients were recovered in theatre rather than in recovery and there were sometimes insufficient staff to look after patients. We observed one occasion where a patient was being recovered in a theatre and a locum operating department practitioner (ODP) was asked to recover the patient because the recovery area was so full no recovery nurses could be released to the theatre. The locum ODP's shift

ended before the patient was recovered but there were no recovery nurses to monitor the patient. A recovery nurse did attend to the patient in theatre but this left the recovery area short-staffed.

Staff in recovery also told us they were often short of one or two recovery nurses on early and late shifts. They said that when there were no available inpatient or intensive care beds, patients had to stay overnight in recovery. However, there were insufficient staff on the team to cover the night shift. In order to provide overnight care, a recovery nurse who was scheduled to work the day shift would instead work the night shift, which left the day shift short of a nurse. Staff told us they sometimes had agency cover to make up the shortfall in nursing numbers but not always, because an agency nurse with recovery experience was not easy to find. We looked at the staff rotas for recovery and found some shifts were not filled.

Staff on ward 1 told us there were not enough physiotherapists for all the patients coming through the unit. Minutes from the October 2013 clinical governance meeting for trauma and orthopaedics also raised concerns about the lack of physiotherapy staff. Clinical governance meetings identified shortages of nurses on wards 1 and 3. Staff in theatre and on surgical wards told us there was often a lack of porters. This meant clinical staff, usually nurses, often had to transfer patients from one area of the hospital themselves when it was not their role to do so. Their concern was that this practice put additional pressure on already stretched services.

We found the day surgery unit, which was being used as a ward, was staffed by one agency nurse who was responsible for nine patients, eight of whom had had surgery. We were told that two agency nurses were originally scheduled on the rota; however, one of the nurses was taken to work on the gynaecology ward because the ward was short-staffed. The agency nurse on duty had not had any identification checks on their arrival on the unit. The nurse told us they had worked on the unit before and gave intravenous drugs and medication. The nurse's credentials and competence were not checked and the nurse was unsupervised.

Mandatory training

Theatre staff told us they attended mandatory monthly academic half days in order to improve the quality of the surgical care they provided. Staff in theatre also told us they had annual mandatory training that they did in their own time because they were not given time to take the training during their working hours. Some nurses told us there was confusion about who was responsible for assessing nurses' competence in areas such as cannulation and taking bloods. There was disagreement about whether this was the responsibility of managers in theatre or of the practice development team. As a result, nurses whose competency needed to be assessed were not assessed and this put additional pressure on other theatre staff to perform these activities.

All the ward staff we spoke with told us they had their annual mandatory training. This included training in health and safety, fire safety, manual handling, and infection control. New nurses told us they had a thorough induction which included mandatory training, preceptorship, and a period on a ward where they were supernumerary. We received mixed responses from ward staff in relation to professional development and appraisal. Most of the surgical staff we spoke with told us there was little, if any, time for professional development due to workload pressures. Just under half the staff we spoke with had not had an appraisal in the last year; most of these were night staff.

The General Medical Council's national training scheme for junior doctors found junior doctors at Wexham Park Hospital felt less supported than their peers at other hospitals. This was the case for junior doctors working in general surgery, plastic surgery, trauma and orthopaedics, and urology. Feedback from some of the junior doctors we spoke with was that they did not all have an induction. Although they had an induction to the trust, they did not always have an induction to their role and so did not always know what was expected of them. However, they also told us they could raise concerns if they had them and felt well supported generally.

Monitoring safety and responding to risk

Staff on surgical inpatient wards had a clear focus on patient safety. Information from the trust's nursing and midwifery 'dashboard' for each of the surgical wards we visited showed that performance against key safety indicators was good. This included information about instances of new pressure ulcers, falls, catheter-related urinary tract infections, and venous thromboembolism (VTE) assessment. The only exception was on ward 3, which showed 75% compliance with catheter care protocols in January 2014 against a target of 100%. This represented a

decline from the previous month's performance which showed 80% compliance. We spoke with staff on the ward. They were unaware that such an audit existed and were not aware of the need to improve. They said audit results were usually fed back to them at team meetings.

Medicines were stored and administered appropriately. We found, however, that prescriptions on patients' drugs charts could not be traced to the doctor who made the prescription as doctors' did not print their names on the drug chart. A pharmacist we spoke with told us illegible signatures on drug charts without printing their names, was a known problem that had been outstanding for some time. The inability to identify prescribers was a particular problem for the pharmacy team because they could not trace the prescriber when there was a medication error. This posed a risk that medication errors would be repeated. There were no plans to address the issue and it was not identified on the trust's risk register. We looked at drug charts on the day surgery unit. These showed that antibiotics were not being prescribed in accordance with the medicines management policy. There was also no stop date for the antibiotics, which meant patients may receive antibiotics for longer than necessary.

Anticipation and planning

Anticipation and planning of day-to-day activities in theatre and on surgical wards was good but was often hampered by the lack of available inpatient beds. Staff at all levels of the organisation told us that the hospital faced severe pressure to find open beds for patients. This had a knock-on effect on each area of the hospital and made it difficult for surgical and ward staff to adequately anticipate and plan effectively to ensure they maintained safe levels of care.

The failure to anticipate and plan care so that it was safe for patients was a particular concern on ward 20. This ward was intended to be a gynaecology ward but we found medical, surgical and gynaecology patients mixed together on the ward. All 22 beds were full. Patients with dementia were bedded next to women who had miscarriages. Patients who recently had general surgery were mixed with medical patients who were very sick. Staff told us that trying to meet the needs of three different groups of patients was overwhelming at times because they did not have enough staff for the level of acuity on the ward. They told us they were allowed to request an additional healthcare assistant when they had a high volume of medical patients but they could not always get someone to fill the shift.

Staff told us, however, that a senior doctor from the medical division of the hospital had been assigned to ward 20 in order to ensure that appropriate medical support was available when it was needed. The doctor told us the hospital tried to group medical outliers by specific conditions; for example, the medical outliers when we visited ward 20 were respiratory patients. The doctor assigned to the ward usually worked on the hospital's respiratory ward. Ward staff felt this system worked well as it gave them a named point of contact for medical patients on their ward. There was no similar system for surgical outliers. Ward staff told us it was sometimes difficult to find a surgical doctor when they needed one. Junior doctors told us it was sometimes difficult to find patients because they were moved from ward to ward so often. One group of junior doctors described surgical ward rounds as a 'safari' because the teams needed to search for their patients.

Are surgery services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

National clinical audits were completed, such as the National Hip Fracture Database, and the trust's performance was similar to that of other trusts. Data from the National Joint Registry showed the number of knee and hip surgery revisions performed at this trust was similar to other trusts, although it performed slightly more hip surgery revisions than the national average. The trust was found to be performing within expectations for four of the five national bowel cancer audit indicators. It performed significantly worse than the national average for data quality. Information on patient reported outcome measures (PROMs) were gathered from patients who had groin hernia surgery, hip or knee replacements, or varicose vein surgery. Patients were asked about the effectiveness of their operation and the data showed no evidence of risk.

Inadequate

Surgery

Performance, monitoring and improvement of outcomes

Overall mortality rates for surgical patient conditions covering 30 days after admission were similar to those of other trusts and there was no difference between weekday and weekend mortality. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's HSMR was significantly lower than expected. Mortality rates for trauma and orthopaedics were better than expected. Mortality rates were monitored and actions taken to address any issues that arose. For example, the trust commissioned an independent review of its mortality rates for fractured neck of femur (hip) surgery and found it was an outlier for the year February 2011 to March 2012. The trust responded to this issue and mortality rates had improved.

Staff, equipment and facilities

There were not always enough appropriately trained staff to meet patients' specialist needs. This was a particular concern on ward 20. The nurses on ward 20 were trained general nurses with a background in women's health. This meant their training emphasised giving emotional and psychological support to patients and focused less on physical care and treatment. As a consequence, staff felt they did not always have the appropriate training or confidence to care for the medical and surgical patients on their ward. For example, many of the patients we saw on ward 20 were either confused or had dementia. None of the staff we spoke with, including the matron, had training in caring for people with dementia. Staff told us they cared for all their patients as best they could but were concerned that the care they were able to offer did not meet the needs of the people coming onto the ward and could, potentially, result in unsafe care.

Multidisciplinary working and support

There was a strong sense of team work among many of the theatre staff, particularly those who worked in recovery. We observed theatre and recovery staff working well together under pressure. However, some teams within theatre did not work well together. Many staff told us they were bullied and humiliated by those in supervisory or managerial positions. Staff who had not been bullied themselves told us they had witnessed other colleagues being bullied. They said that, despite raising concerns, the issue had not been addressed.

There was good multidisciplinary team working on surgical wards. There was good involvement of doctors, nurses, therapists, and pharmacists in patient care. Hip patients on ward 1 were seen by physiotherapists, although staff said physiotherapists did not always have enough time to spend with patients. Staff from different disciplines said they felt they could talk to one another openly. Consultant ward rounds took place daily and we saw this in practice. There were arrangements for accessing doctors and medical advice when needed, although doctors and nurses told us medical cover was often stretched, particularly at night and weekends. There were procedures in place for contacting intensive care staff when required. Staff knew these procedures and told us they worked well.

Are surgery services caring?

Requires improvement

Compassion, dignity and empathy

Patients' experiences of care were mixed. Overall, patients spoke well of staff and were very pleased with the care they received. Almost all the patients we spoke with said staff were compassionate and kind. They felt they were treated with dignity and respect. Patients told us staff responded to call bells although they were sometimes so busy that the response was an acknowledgment that the call bell button had been pressed rather than a response to the patient's needs.

We observed notable examples of very good care where staff supported and comforted patients who were particularly ill or vulnerable. Staff in these areas were exceptionally caring and responsive to people's needs and patients felt well looked after. On ward 20, we observed staff speaking calmly and comfortingly with patients who had severe dementia. They treated the patients with dignity and communicated well with them. Patients on ward 20 praised the care they received by staff. One patient told us: "[The nurses] work so hard and they still have time for me." We looked at four comment cards for the ward and all of them described staff as 'caring'. On ward 3, we observed a patient who did not feel well enough to eat during mealtime but who did not want their food to be taken away in case they wanted to eat it later in the evening. Rather than allow the patient's food to get cold, catering staff agreed an alternative meal with the patient which could be

brought when the patient was ready to eat We also saw examples of very kind and compassionate care from recovery staff. Staff we spoke with in recovery were empathetic and clearly concerned about the well-being of patients in their care. We observed that recovery staff did whatever they could to make patients comfortable.

There were some instances where patients' experiences were very poor, particularly on ward 2. Patients on this ward cited lack of compassion and empathy from some members of staff, particularly at night. Medical outliers on this ward sometimes felt, in one patient's words, "abandoned". They said ward staff did not always know what care or treatment had been agreed with doctors and did not listen when patients tried to tell them.

While we found adequate standards of privacy and dignity in most of the areas we visited, we found a lack of privacy and dignity in the theatre admissions lounge. Patients were usually consented for surgery during outpatients appointments and details of the surgery were discussed with them at that time. However, there were occasions when patient consent was taken in the theatre admissions lounge and we observed this to be the case. This was a concern because there were no confidential areas in the theatre admissions lounge. While there were individual patient bays and staff used curtains to screen patients from the view of others in the lounge, conversations about patients could be clearly overheard. Staff told us it was unusual to take consent in the theatre admissions lounge but it happened sometimes because either a patient was not consented or consent paperwork had been lost.

There were also concerns about privacy and dignity on ward 20. Sometimes there were no available beds for women who were referred to the ward from accident and emergency (A&E) because of actual or suspected miscarriage. Women who were waiting to see a doctor or who were waiting for a bed were lined up on seats along a corridor in view of other patients and directly across from two single rooms that were used for women who had miscarried. Staff told us these women often required privacy and considerable emotional support, neither of which was possible given the arrangement of the ward. Instead, staff often had to console and counsel women within earshot of most of the other patients on the ward.

Throughout the wards we visited, we found patients were usually helped to eat when they needed assistance to do so. However, staff on some wards told us they sometimes struggled to help people eat and drink when there were large numbers of patients who needed assistance.

Involvement in care and decision making

The surgical patients we spoke with felt involved in their care and in decision making about their care. Many of the patients we spoke with told us they were given adequate information about the specific surgical procedure that applied to them. They said risks and alternatives were explained to them. Patients who were consented during an outpatients appointment told us consultants were caring and professional. They felt they had time to ask questions and that their questions were answered in a way they could understand. All the patients we spoke with said they had been asked to give their consent to surgery in writing. We found evidence of this in the patient records we checked.

Trust and communication

Almost all the surgical patients we spoke with said staff were open and friendly. Surgical patients felt there was good communication between themselves, doctors, and nurses. They said they were told what to expect both before and after surgery. After surgery, they were given regular updates on how they were healing.

Patients we spoke with raised concerns about some staff whose first language was not English. They said it was sometimes difficult to understand what staff were saying and found this frustrating. This was also an issue raised by staff across the trust. They said the language barrier sometimes made it difficult to work in teams and it was difficult for patients, especially those with dementia. During our interviews with ward staff, we found some of them were not able to speak more than very basic English. We found it difficult to understand these members of staff when we spoke with them and they struggled to understand our questions.

Emotional support

Many patients told us they were given adequate emotional support when they needed it. However, an equal number said staff were very caring but were so busy that they did not often have time to offer emotional support.

Are surgery services responsive to people's needs?

Inadequate

Surgery

(for example, to feedback?)

Inadequate

Meeting people's needs

Although ward staff worked hard to meet patients' needs on day-to-day basis, patients' needs were often not met because established systems or processes were not followed, did not exist, or were inappropriate.

We spoke with two women who had been seen in A&E and who subsequently were admitted to ward 20 as a result of an actual or suspected miscarriage. They told us they were sent to ward 20, a gynaecology ward, where they then waited between an hour and an hour and a half to see a doctor. The comment cards we looked at in ward 20 praised the care given by ward staff but criticised the long waiting times. When we talked to staff on the ward, they told us there were concerns about the care pathway for women who needed to use services on the gynaecology ward, especially women who had miscarried having to go through A&E. Women who had recently miscarried often had to sit on hard wooden chairs while waiting to be seen by a doctor or while waiting for a bed. We observed this during one of our visits to the ward.

The use of recovery as a holding area for patients made it difficult for staff to meet the needs of patients who needed to be discharged. This was because recovery was not designed with the facilities that would normally be required to prepare patients for discharge. For example, recovery staff told us that in order for patients to be discharged, they first had to eat and drink, use the loo, and be able to walk. However, there were no kitchen facilities in recovery. Staff told us they used the clean utility room as a makeshift kitchen because there was other facility for preparing food nearby and patients could not be discharged home until they could eat. We saw a tea kettle and food in the clean utility room. Staff used a countertop in the middle of recovery to prepare dressings, syringes, and medicines instead of using the clean utility room in which they were intended to be prepared.

There were also inadequate toilet facilities for patients. One toilet was designated for patients and visitors. In the bathroom, there were no support rails to help prevent falls and there was no emergency alarm bell. The door also locked from the inside. Staff told us they asked patients not to lock the door so that they could enter the toilet if the patient needed help. We found a manual bell in the bathroom. Staff told us patients could use this if they fell and needed help. The bell, however, was stored on top of a radiator that was about a metre or more away from the toilet. If a patient fell, they would not have been able to reach the bell to sound an alarm.

Records we saw showed bed pressures in the recovery area were a concern from January 2013. However, the risk assurance framework did not identify staffing and capacity pressures in the recovery area as risks. Many of the risks identified on the risk register showed no evidence of review since May 2013. We found post-operative patients were kept in recovery for long periods of time, sometimes six hours or more. This was not identified as a risk on the department's risk assurance framework. During one of our visits, we found patients who should have been moved to a high-dependency bed or to intensive care who were often kept in recovery for hours, often overnight, because there were no appropriate beds for them. We also found post-operative patients were recovered in theatres because there were no beds for them in recovery. There were no risk assessments for any of these circumstances to ensure that patients were cared for in an appropriate environment and by an adequate number of staff. We asked whether there were standard operating procedures for keeping patients in recovery for long periods. Staff and managers told us there were no such procedures. There were no systems for risk assessing patients for risks of falls or pressure ulcers, not even when they stayed in recovery overnight.

Vulnerable patients and capacity

Patients we spoke with told us they had been asked for their consent prior to surgery. They told us risks and benefits were explained to them and they were given information about what to expect from their surgery. The patient records we looked at reflected this.

Where patients showed signs of confusion, staff used a dementia screening tool to determine whether patients had dementia and the effect this would have on their consent. Where patients were found to be unable to consent to decisions about their care, mental capacity assessments were undertaken and staff asked appropriate questions to test capacity.

Some patients, such as those with dementia, were occasionally assigned 'specials', i.e. their own nurse who could provide them with one-to-one care. Staff told us

specials were not always available and did not provide round-the-clock care but could be requested for people with very complex needs. During our visits to the surgical wards, we found specials were on shift and assigned to specific patients who had particularly complex needs. Staff rotas showed specials were used from time to time.

Access to services

Many of the patients we spoke with were very unhappy with administrative procedures around pre-operative assessments and follow-up appointments. They told us these were difficult to get and were often cancelled, repeatedly, at short notice. Some elective patients told us their surgeries were cancelled at short notice and they were not informed of the cancellation. Patients who had experienced delays in having their surgery told us they were not always informed of the delay and were not given any information about expected waiting times. A few patients told us they had arrived at the hospital for their surgery and were sent home because there were no available inpatient beds.

The hospital was not meeting the national waiting time target of 18 weeks from referral to treatment for patients undergoing planned general surgery, trauma, orthopaedic surgery. This was mainly due to increased numbers of required emergency surgeries and the unavailability of hospital beds. In response, the trust referred some patients who required low-risk surgery to independent hospitals and to other NHS trusts. There were also additional theatre lists during the weekend to contain the backlog of delayed surgeries. Staff were clear that patients would have surgery on the basis of clinical need so that the most urgent patients were seen first.

There were significant delays in accessing radiology services. Some of the patients we spoke with told us they had been waiting days for an X-ray or a CT scan. Patients told us arrangements were made to take them to radiology and they were then cancelled with no explanation. One patient told us: “The nurse said I might have my scan tomorrow, the next day, or next week!” Patients often felt that the delay in having their X-ray or scan was prolonging an otherwise unnecessary stay in hospital. This view was shared by doctors, who told us patients were staying longer in hospital because they were not having their diagnostic tests.

On one of our visits to theatres, we found a patient’s operation was delayed by at least an hour and a half due to the lack of a radiographer based in theatres. The patient was in theatre waiting for surgery. As a result, the remainder of the theatre list was delayed and the surgery overran. Recovery staff told us there was usually a radiographer based in theatres but that the radiographer had ‘disappeared’ earlier in the afternoon and staff did not know where they had gone. No other radiologists were available.

There was also information about how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). There were information leaflets on all the wards we visited and in theatre about different types of conditions and procedures. There was also information explaining some of the techniques and models of care that were used to help patients recover from surgery. For example, there was a large poster on the wall explaining what the enhanced recovery model was and the benefits it had for patients.

Although there was adequate information, it was provided only in English. This was a concern because the population the hospital serves is very diverse and a significant percentage of the population does not speak English as a first language. Most of the staff we spoke with told us there was a professional interpreting service but this was hardly used. Instead, staff relied on relatives, on other patients, and on other members of staff to translate for patients who could not speak or understand English. In several cases, staff told us they sometimes used domestic staff as interpreters. The trust’s website had a facility for translating very limited information on its homepage. When we tried to use the facility, we found it did not always work and information about using the translation facility did not always appear on the website.

Leaving hospital

Staff told us they felt pressured by bed managers to discharge patients in order to free up beds. They said discharges were rushed. This concern was also identified by the trauma and orthopaedic clinical governance meeting in October 2013. Minutes from the meeting noted concerns about rushed discharges and, as a result, patients not being given required outpatient appointments.

Some patients, particularly those with complex needs, were not always discharged on time. Nursing staff told us they often found it difficult to locate medical doctors to review medical outliers on their wards and so patients who were fit for discharge were sometimes kept in hospital

unnecessarily. We also found a number of patients who staff told us were fit for discharge but who were unable to be transferred because of inadequate social services support. This meant that patients were at risk of developing hospital infections and their recovery could be delayed. This also limited the availability of surgical beds.

Learning from experiences, concerns and complaints

When we spoke to staff, they said they had received a number of complaints about the quality of the food. They told us the ward did not have its own kitchen facility which made it difficult to keep food warm or to heat it up. In addition, a common complaint patients made to us was about the cost of television and radio services. Most of the patients we spoke with told us that accessing television and radio programmes was very expensive.

There were examples on some wards of how staff had learned from experiences and concerns and had responded to them. One example of this related to work being done to reduce the number of patient falls. On ward 1, staff showed us how they had put together a 'falls map' to identify the areas of the ward where patients were most likely to fall. They used this information to make changes and reduce the risk of patients falling on the ward.

We found that patients' experiences and complaints were not always used to improve services or the effectiveness of treatment. One of the most common complaints patients made to us was about being moved from one ward to the next, especially in the middle of the night, or being moved to and from a number of different wards in a short period. All the staff we spoke with acknowledged that patients were frequently moved from one ward to another and often at night. This long-standing issue remained unresolved at the time of our review.

Are surgery services well-led?

Inadequate

Vision, strategy and risks

We spoke with staff and managers at all levels of the organisation and from various disciplines. There was no unifying vision to bring staff together to achieve a common purpose. When we asked staff about the trust's vision, almost all of them asked us what we meant and then referred to the proposed merger with Frimley Park Hospital NHS Foundation Trust. There was no overarching vision or strategy for developing or improving surgical services. Significant risks were identified at divisional level including capacity pressures and concerns about staffing. However, risks at local team level were not always identified or addressed, for example the concerns raised about capacity in recovery.

Governance arrangements

Although some members of the theatre and recovery team told us they felt well supported by their immediate line manager, more than half told us that when they raised concerns, they were not addressed. They said they felt bullied and were afraid to raise concerns because they would be labelled 'troublemakers'. As a result, many staff told us they stopped raising concerns and reporting incidents. Theatre staff told us they did not get feedback about incidents and complaints. They said they felt frustrated because they had ideas for improving the service but did not feel senior management listened to them. We found staff in theatres were often afraid to discuss their concerns with us openly during our visit. They told us they did not want comments to be attributed to them and were afraid of reprisal from senior managers. A number of theatre staff contacted us independently and under whistleblowing arrangements to discuss their concerns. Staff and managers told us there was no human resources support. An independent panel that reviewed a number of the trust's key policies in relation to raising concerns stated that they were not fit for purpose. This is a breach of Regulation 10, which requires an effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services.

Staff on wards 1, 2, 3 and 20 felt well supported by their immediate line managers. Staff on these wards told us they could raise concerns within their teams and could make changes to practices and arrangements that were within their control. They felt, however, that when concerns were escalated to managers further up in the organisation, their concerns were not always addressed. This was a particular concern for ward 20, whose staff told us they had repeatedly raised concerns about the care pathway of women coming from A&E who had miscarriages and the lack of beds for these women. The view that senior managers did not listen to concerns was also shared by

recovery staff. They told us they had raised repeated patient safety concerns about using the recovery area as a holding place for patients but felt their concerns were ignored

There were systems in place for monitoring the safety and quality of care, although these were more established on surgical wards than in theatre. The quality of care on surgical wards, for example, was monitored through the trust's nursing and midwifery dashboard, which showed that performance against key safety indicators, was generally good. These indicators were mapped to national performance indicators such as the NHS Safety Thermometer for harm-free care. Matrons on each ward had their own ward meetings each month and staff told us these meetings were used to share information and concerns.

Morbidity and mortality meetings were used in some surgical specialties to review incidents and unexpected death in order to identify learning and improve services. However, the frequency and rigour of morbidity and mortality meetings were not consistent across surgical specialties. Minutes from the trauma and orthopaedic specialty showed they were well attended by consultant orthopaedic surgeons, orthopaedic registrars, junior doctors, matrons, therapists, and pharmacists. Staff from orthopaedics and trauma told us there was good review of mortality and morbidity cases. They felt governance arrangements for their specialty were good. In contrast, staff told us that governance for other specialties required improvement and needed more consistency. Staff told us there was often inadequate time allotted for discussion of morbidity and mortality cases. Minutes from the mortality and morbidity meetings from the urology department lacked detail and it was not clear who attended these meetings or how often the meetings were held. We saw minutes from the clinical governance group for general surgery but there were no documented morbidity and mortality meetings for this specialty. Staff we spoke with stated there were cultural problems within general surgery that made it difficult for them to engage with the department.

There were governance meetings both at specialty and divisional level. Divisional healthcare governance meetings showed a review of divisional risk registers, capacity pressures, infection control issues, 'Friends and Family' scores, incidents, and sometimes audit results. Specialty clinical governance groups explored similar issues within their specialties.

Leadership and culture

Services in surgery were not well-led. Senior managers and lead clinicians did not have a good understanding of the performance of their department. For example, although consultants and surgeons had professional appraisals, which are required of all doctors, the trust did not monitor their performance against key performance indicators or clinical outcomes. This meant the trust was unable to compare the performance of surgeons against one another or against peers in other specialties. This was a particular concern for this trust because of long-standing allegations of unsafe practices made by surgeons against their colleagues.

Surgical staff were not always held accountable for maintaining the quality of the department and there was often a reluctance to respond to change and ensure that safety procedures were consistent. Staff told us this was particularly the case in general surgery and urology. Theatre staff told us the department needed a "culture change", especially among consultants, who, they felt, were not always willing to work as part of a team or engage with new standards of practice.

In recovery, capacity pressures, both in staffing numbers and patient mix, were not well managed. Although recovery staff worked well together there was no managerial support for recovery staff. We saw recovery nurses trying to care for patients while also chasing bed managers for open inpatient beds and managing demands from theatre colleagues for recovery beds.

Staff across various disciplines and grades told us there was a pervasive culture of bullying throughout the surgical division. Allegations of bullying and harassment were a particular concern in theatre and among consultants and doctors. Staff in theatre, including recovery, told us they felt bullied by middle and senior managers. When they raised concerns about patient safety, they said they were ignored. Theatre and recovery staff told us they had stopped reporting incidents because they did not receive feedback when they did so and their concerns were not addressed. Some consultants felt they were bullied and discriminated against because of their race and were performance

managed for minor issues that were overlooked when committed by other colleagues. Other consultants and doctors told us there was a culture of bullying that extended beyond race or ethnicity.

Patient experiences, staff involvement and engagement

Most of the patients we spoke with felt individual members of staff, including doctors, nurses, healthcare assistants and therapists, were usually caring and compassionate. Where they felt services needed to improve was in ensuring that systems and processes fostered and supported caring and compassionate services. Patients did not feel services were always designed around their needs or from their perspective.

Where patient experiences were identified as being poor, there was sometimes inadequate action taken to improve their experiences. In the August 2013, 'Friends and Family' test, the trust's day surgery unit, ward 2 and ward 20 were the least likely of the surgical wards to be recommended by patients to their friends and family. Against a trust average 'Friends and Family' score of 68, the day surgery unit achieved a score of 58, ward 2 had a score of 60, and ward 20 had a score of 48. More recent data provided by the trust showed that, in December 2013, scores for wards 1 (trauma), 2 and 3 were at or above the trust average but scores for the day surgery unit, ward 1 (hip) and ward 20 remained low.

Learning, improvement, innovation and sustainability

There were examples of learning and improvement, especially on wards 1 (trauma) and 20 and in recovery. However, improvements and innovations were often led by individual members of staff in an effort to make improvements for patients on their specific wards rather than by the organisation as a whole.

Good practice was not shared between wards so that staff could learn from one another. Staff did not feel they worked in a learning culture. They said they often did not have time to develop their skills and were not given sufficient organisational support to develop themselves or the services in which they worked. Many of the staff we spoke with were keen to learn and improve but felt they were not given information about how they could do better. In many cases, staff did not get feedback from incidents, complaints, or audits. Where staff did get feedback, they told us they were told "what was wrong but not how to make it right".

Good

Intensive/critical care

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

Information about the service

The trust's critical care unit included the intensive therapy unit (ITU) and the high dependency unit (HDU). These were located together and the unit had 12 beds. An intensive therapy unit outreach team assisted with the care of critically ill patients who were on other wards throughout the hospital. The critical care service had consultant cover 24 hours a day.

We talked with two relatives visiting the unit and seven members of staff. These included nursing staff, a doctor, a consultant, and senior management. We also talked to two patients who had come out of intensive care and who were inpatients on surgical wards. We observed care and treatment and looked at two sets of patient records, including medical and nursing notes. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Patients received safe and effective care. Patients and relatives we spoke with were very pleased with the care they received in ITU and spoke highly of the staff. Clinical outcomes for patients in the unit were good, often above the national average. Staff worked well together as a team and were enthusiastic about their work. However, we found the unit was functioning with an unacceptably high staff vacancy rate. This was identified on the trust's divisional risk register and recruitment was in progress. There was also a high number of non-clinical transfers of patients from ITU to other hospitals because inpatient beds were not available elsewhere in the hospital. Patients who needed critical care were sometimes cared for by recovery staff in theatre because there were no available beds in ITU.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

There were systems in place to monitor the quality and safety of care. The unit benchmarked its performance against that of other intensive care units around the country using independent national data from the Intensive Care National Audit and Research Centre (ICNARC). ICNARC provides information on the types and numbers of admissions to the unit, mortality, transfers, readmissions, length of stay and hospital-acquired infections. ICNARC data for January to March 2013 showed that mortality rates, lengths of stay and cases of hospital-acquired infection were about the same as those in other intensive care units across the country.

The unit also monitored against key safety indicators that were linked to the national NHS Safety Thermometer for harm-free care campaign. These included information about instances of new pressure ulcers, catheter-related urinary tract infections, and venous thromboembolism (VTE) assessment. Information from the Health and Social Care Information Centre, which collates data for the campaign, showed that the unit's performance against these indicators fluctuated throughout the year but, overall, the unit maintained high levels of harm-free care.

Learning and improvement

Staff we spoke with told us they were encouraged to raise concerns and supported to learn from incidents. They told us about an incident involving a medication error and how staff were encouraged to learn from this. Themes from incidents and complaints were shared at monthly staff meetings. Staff told us of plans for an ITU newsletter that was intended to improve the sharing of information about incidents and complaints. Staff felt there was a culture that was focused on learning and improvement.

Systems, processes and practices

We observed very good care on ITU. The unit was calm, ordered, and clean. There were regular nursing ward rounds throughout the day that involved a doctor. There was a strong sense of patient safety amongst staff. There were good handover arrangements in ITU to ensure safe and effective handovers of patients during shift changes. We observed a general group handover and then individual handovers at each patient's bedside. Each patient in an intensive care bed had one-to-one nursing care at all times, and for patients in a high-dependency bed there was one nurse caring for two patients. This followed recognised guidelines.

There was an outreach service that ran 24 hours a day, seven days a week, although the service was often limited because of lack of staff, especially at night. There was only one outreach nurse per shift and when that nurse was sick, it was not always possible to find a replacement. Although all ITU staff were trained to provide care on the unit, there were often insufficient staff on the unit to make up the shortfall when an outreach nurse was unavailable. When a full outreach service could not be provided there were arrangements for responding to requests for emergency support. Ward staff told us when the outreach service was limited, their requests for advice or assistance were dealt with although not as quickly. Managers were aware of this issue and told us existing ITU staffing levels were low but recruitment was in progress.

All the staff we spoke with on the surgical wards knew about the outreach service and when to contact the service for help. An early warning tool, which was used to identify patients whose medical condition was worsening, included instructions for contacting ITU outreach. Feedback from staff on surgical wards was that the outreach service was very responsive and supportive. They said ITU staff came out to wards almost immediately after outreach was called.

We looked at staff rotas and found shifts were regularly filled with adequate numbers of staff. Although there were sufficient levels of staff in ITU, it was functioning with a high vacancy rate. This issue was identified on the trust's divisional risk assurance framework and a recruitment drive was in progress at the time of our visit. ITU managers told us they were expecting eight new nurses. In the interim, the unit relied heavily on bank and agency staff to ensure safe staffing levels. Managers told us the agency and bank staff used on the unit were usually booked for long periods to allow for consistency and continuity. These members of staff were also given specialist training by the unit to ensure that they were competent to provide safe care to patients. All the staff we spoke with felt this system worked well.

The unit was clean and we observed staff either washing their hands or using hand hygiene gel. Audits from April 2013 to January 2014 showed compliance with hand

hygiene standards fluctuated between 80% and 90%. There was an action plan to address these concerns. One session of hand hygiene training had already been provided to ITU staff from the trust's infection control team and additional sessions were to be organised.

Patient records were stored electronically. We checked two sets of patient records and found that each patient had risk assessments and care plans that were reviewed daily. Where risks were identified, measures were put in place to minimise the risk of harm to patients. The one exception was that ITU staff did not do falls risk assessments for conscious patients or for those who were regaining consciousness. These patients tend to be at high risk of falls because medication they are given often makes them prone to confusion, especially as they regain consciousness. There was regular and frequent multidisciplinary input into each patient's care plans. Pain levels and sedation requirements were assessed. Medication records were clear and medication was given as prescribed.

The unit was purpose-built and facilities were of a high standard. ITU was calm and well-ordered when we visited. Overall standards of cleanliness in ITU were good. Housekeeping standards and cleanliness were regularly audited. Audits showed high levels of compliance with performance measures. Staff told us the hospital had recently undergone a deep clean and cleaning arrangements had been improved. Relatives we spoke with were pleased with the cleanliness of the unit. Store cupboards and sluice rooms were tidy. Hand hygiene gel was available at the entrance to and throughout the unit and at the bottom of each patient's bed. Staff and visitors were encouraged to use alcohol gel and there were large signs educating people on the importance of using hand gel. Infection rates (January to March 2013) were similar to those of other intensive care units for methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections.

Monitoring safety and responding to risk

There was a risk register for the unit and this fed into a division-wide risk register. We found key risks in ITU were identified, such as staffing and high numbers of non-clinical transfers, and these were being addressed.

The unit participated in a number of ITU-specific audits including ICNARC and an audit of ventilation-associated pneumonia. There were also audits of infection control arrangements, cannula care and hand hygiene.

Information from the trust's nursing and midwifery dashboard for ITU showed that performance against key safety indicators was good. This included audit information about patient observations, care planning, crash trolleys, medication, responses to call bell requests, and nutrition and hydration.

There were arrangements for multidisciplinary team working outside the trust through a regional critical care network. Representatives from the trust attended monthly and quarterly meetings of this network.

There was a trust-wide policy on safeguarding. Staff we spoke with were able to explain the hospital's safeguarding procedures and how they would raise a safeguarding concern. They told us they would escalate concerns to the nurse in charge and would also alert the trust's safeguarding lead. Staff could describe the basic elements of the Mental Capacity Act 2005 and how this related to consent to treatment. Nurses told us that doctors undertook mental capacity assessments of patients and where appropriate decisions were made in the 'best interests' of patients. Although the patient records we looked at did not identify a need for a mental capacity assessment we were therefore unable to see how these were done on the unit.

Anticipation and planning

The unit and its services were clearly planned around the needs of patients. Managers and staff were aware of the risks and challenges facing the unit and steps were taken in response. However, the main challenges facing the unit were related to capacity in terms of both available beds and staffing. While the unit was able to respond to pressures around staffing, the pressure on beds was a trust-wide issue that the unit could not resolve in isolation. In order to free up beds, the unit increasingly transferred patients who no longer needed care in ITU to other hospitals. Patient flow and capacity were established risks throughout the hospital.

Are intensive/critical services effective?
(for example, treatment is effective)

Good

Intensive/critical care

Good

Using evidence-based guidance

Patients received care and treatment according to national guidelines. There was a set of admission criteria to determine which patients could be admitted to ITU from wards, theatre, and the emergency department. Intensive care patients received one-to-one care and high-dependency patients had two-to-one care, in accordance with professional requirements.

Performance, monitoring and improvement of outcomes

Outcomes for patients were good. ICNARC data for January to March 2013 showed that the unit's mortality rates, average length of stay and hospital-acquired infection rates were similar to those of other units across the country. They said staffing shortages were also a reason for non-clinical transfers.

Staff, equipment and facilities

There was appropriate equipment including computer monitoring equipment at each patient's bed, ventilators, linen trolleys, resuscitation equipment, and linen trolleys. The records we checked showed that resuscitation trolleys were checked daily and expired equipment was replaced. Staff told us that equipment was checked regularly. They also said there were no problems getting equipment when they needed it.

There were good arrangements for ensuring staff had mandatory training. Staff told us they had annual mandatory training and training was planned far in advance to ensure adequate staffing on the unit. New staff told us there were good induction arrangements, which they felt prepared them to work in ITU. There were two end of life nurses who attended specialist training and then shared what they learned with staff on the ward. Where some staff felt ITU could improve was in supporting staff in their professional development. Staff told us workload and capacity pressures limited opportunities for professional development.

Multidisciplinary working and support

Staff felt they worked well together as team. Those we spoke with were enthusiastic about their work and said they enjoyed working on the unit even though it was often very busy.

Staff told us there were multidisciplinary meetings once a month. These were attended by nurses and doctors to review specific concerns, look at any deaths, discuss changes, and make improvements. Nurses and doctors felt there was good collaboration between nursing and medical teams.

During one of our visits, we observed a well-run, comprehensive microbiology ward round. This was led by a consultant microbiologist who was accompanied by a trainee and involved all the staff on the ward, including nurses, trainees and a pharmacist.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Patients and relatives we spoke with said care on ITU was good. They frequently described staff as 'caring', 'attentive', 'dedicated' and 'brilliant'. Patients and relatives felt that privacy and dignity standards were well maintained. They told us curtains were regularly used to provide privacy during intimate examinations and for personal care. During our visits, we found nursing staff were compassionate and empathetic. We observed a nurse blow-drying and combing one patient's hair because the patient was unable to do this themselves. One patient's relatives said: "Staff are very human, very caring, and very approachable and made the whole process easier."

Involvement in care and decision making

We spoke with two patients on the surgical wards we visited who were discharged from ITU and both said they felt involved in making decisions about their care. One of them told us: "I was involved as much as I wanted to be." The other said: "They explained things to me … and [the staff] weren't patronising … they were good at talking me through things." Patients and relatives said staff were friendly and easy to talk to. One relative told us this "made it easier to have those difficult conversations about what happens next".

Trust and communication

Most of the patients and relatives with whom we spoke about ITU stated that communication from staff was good. There was a leaflet with information about ITU. There was one morning, however, when we observed immediate

Good

Intensive/critical care

family members visiting a patient who had been admitted to ITU. They told us they had no information about the patient's progress and were very anxious. When the family arrived on the unit, they were told they had to wait for tests to be done. After an hour of waiting, the family was told they could not see the patient because they were having personal care. After two hours and 15 minutes of waiting, the family complained and were allowed onto the unit.

During our observations on ITU, we saw good staff communication with patients. We observed staff asking patients whether they were comfortable, talking them through various procedures, and explaining to them what they should expect.

Although patients had few complaints about ITU, they told us all the staff on the unit wore the same uniform which made it difficult to tell who was who and they did not know who to approach with questions or concerns.

Emotional support

Patients and relatives felt their emotional needs were well supported. The unit had a specialist organ donation nurse who supported relatives in making decisions about organ donations, end of life care and withdrawal of treatment. There was no bereavement support for relatives.

Where relatives said ITU could be improved was in the relatives' waiting area. They said the area was cold, uncomfortable and 'depressing' which, they felt, did nothing to alleviate their anxieties. During our visit, we found the relatives' waiting area was physically cold and had no heating. Also, the ceiling was leaking in two places and the plant in the room had a thick layer of dust on it.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Care was planned and provided around patients' individual needs. Staff we spoke with were focused on treating patients as individuals and getting the best outcomes they could for each person. The patient records we looked at showed individualised care planning with targets and goals tailored to each patient's needs. There was a quiet room for interviews and a room where relatives of critically ill, unstable or dying patients could stay the night

Access to services

Patients and relatives we spoke with said access to ITU services was good. They all felt admission to ITU had been achieved within a reasonable time. We found, however, access to ITU or high dependency unit (HDU) bed was sometimes delayed due to a lack of available inpatient beds either within ITU or on surgical wards. This was particularly evident in the theatre recovery area, where post-operative patients who needed a bed on the intensive care unit could not get one and were cared for overnight in recovery. Capacity issues within the hospital also affected the timeliness of patients being discharged from ITU. We found that patients who were sufficiently well to be admitted to a hospital ward were sometimes kept in ITU because there was no available bed for them elsewhere in the hospital.

Relatives told us ITU was not well signposted and, therefore, difficult to find. We found this to be an accurate observation. We struggled to find ITU. The sign was small and mounted on a wall that could not be seen from the main corridor.

Leaving hospital

Patients who were discharged to other wards had follow-up visits by the ITU outreach team. There was also an ITU follow-up clinic for patients after they had been discharged from hospital. There was information in the relatives' waiting area about an organisation called SITUP that offered support to ITU patients and relatives after discharge.

Learning from experiences, concerns and complaints

The unit regularly sought feedback from patients and next of kin. We observed information leaflets inviting feedback from patients and relatives in the relatives' waiting room. Feedback was reviewed and audited. Audit results from October to December 2013 showed patients and relatives felt their needs were met and rated the standard of care in ITU highly.

A clinical governance report from December 2013 showed there was learning from incidents. ITU had several pressure

Good

Intensive/critical care

ulcer-related incidents. An investigation found a need to improve communication within the team about pressure ulcers and a need for staff training in the use of specific pressure-relieving equipment.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

There was no overarching vision or strategy for developing or improving intensive care services. Staff told us, however, there were "quality priorities" that they understood and that meeting patients' needs was one of these priorities. Significant risks were identified by the unit and at divisional level, including capacity pressures and concerns about staffing.

Governance arrangements

ITU was well structured and staff with the team took lead roles to support different initiatives, such as outreach, follow-up clinics, infection control and practice development.

The service monitored the safety and quality of care, and action was taken to address identified concerns. Performance was monitored at divisional level and reported to the trust's healthcare governance committee, a subcommittee of the board.

Leadership and culture

The intensive care unit was well-led at ward level. Staff on ITU were passionate about their work and were responsive to patients. The culture of the unit was focused on patient safety and patient experience. However, there was little evidence of leadership of ITU at divisional level, which meant that concerns were not always escalated to the board so they could be recognised and addressed. Staff said their immediate managers were very supportive; however, senior divisional leads were not always visible. Staff on the unit told us senior managers and the trust's executive team sent out emails but otherwise did not engage with them.

Staff on the surgical wards we visited said the outreach team was supportive, responsive, and effective, even when outreach services were limited. The outreach service was well known and well regarded by patients and staff.

Patient experiences, staff involvement and engagement

Good arrangements were in place for getting feedback from patients and their relatives. Feedback was used to monitor and improve the service.

Staff felt involved in making decisions about how the unit was run and said they could raise concerns if they had any.

There were good arrangements in place for ensuring that ITU staff were trained, including specific training for long-term bank and agency staff. New staff said there were good induction arrangements in place and they felt well prepared to work on ITU.

Learning, improvement, innovation and sustainability

Staff felt they worked in an environment that supported learning and there were examples of learning and improvement that involved the entire team. Results of audits and patient feedback were shared at monthly staff meetings. An area in which staff felt they could improve was in access to continuing professional development (CPD). They said CPD was limited because capacity pressures meant staff could not be released from the unit to take up development opportunities.

Inadequate

Maternity and family planning

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

Information about the service

Wexham Park Hospital maternity service delivered 4,935 babies during 2013/14. The maternity services include a maternal fetal assessment unit (MFAU), an antenatal clinic, and a triage department consisting of three cubicles and one consulting room. The antenatal ward has three four-bedded bays and two single rooms. Each bay has its own shower and toilet, and there is a bath and toilet that are easily accessible for wheelchair users.

The labour ward has 10 dedicated rooms for labouring women. Induction beds are within the antenatal ward and elective caesarean section beds are allocate on the post natal ward and are carried out in main theatre. The labour ward provides care for women with low-risk and high-risk pregnancies and one of the delivery rooms has a birthing pool. There is one dedicated obstetric operating theatre adjacent to the labour ward, but there are no maternal high-dependency beds.

The midwife-led Isis birth centre on the floor above the labour ward has six birthing rooms, of which two have birthing pools.

The 25-bed postnatal ward is designed with four five bedded bay areas with access to bathroom/toilet facilities. There are five single roomed bays which flex between NHS and NHS amenity beds. Care for women using the Astor suite is provided by maternity support workers overseen by the postnatal midwifery team.

We talked to seven women, their partners and 41 staff, including care assistants, midwives, nurses, nursery nurses, doctors, consultants, and senior managers. We observed care and treatment and looked at six care records in order to track the women's journey from admission to after the delivery. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Inadequate

Maternity and family planning

Summary of findings

We had significant concerns with regards to the quality and safety of care provided at Wexham Park hospital. There was an overall prevailing culture of bullying and lack of joined up working across the multidisciplinary team. Incidents were not always being reported and there were accusations of improper downgrading of their severity alongside suggestions of defensive practice. Lack of leadership within the unit had left staff disengaged and distracted staff from patient centred care.

Although midwife to birthing ratios were often satisfactory, the department was reliant on bank or agency staff. Consultant cover is in line with Royal College of Obstetricians and Gynaecologists guidelines, though we were given examples of how overnight staffing arrangements meant that some mothers were unable to deliver at the originally planned time.

We found that not all clinical guidelines had been updated, including those pertaining to emergencies such as maternal haemorrhage. Concerns had been raised both internally and externally with regards to the caesarean section rate for the unit. There did not appear to be a robust action plan to address this.

According to the CQC maternity survey 2013 the trust performed in line with other maternity units, although we received mixed feedback during our inspection. Some new mothers were very positive whereas others gave us examples where they reported staff to be rude and to not communicate well with them.

Are maternity and family planning services safe?

Inadequate

Safety and performance

There was a system in place to report adverse events, accidents or near misses and staff across various grading and job roles understood the system in use when we spoke with them. The electronic system was known as Datix and all staff we spoke with had access to this. Feedback from reported incidents was said by staff to be communicated at incident review group meetings. We saw within the labour ward quality report that 48 incidents had been reported in January 2014, all of which were either being investigated or were overdue. A newsletter was said to be circulated to all staff by the CNST / audit midwife, with information such as any themes that had been identified from the incident review meetings. We were able to review a newsletter entitled 'Maternity In-Touch Clinical Governance Newsletter' for January 2014 and saw evidence of the cascade of information as described to us.

There was a degree of confidence in the reporting by midwives and nurses using the Datix system, but it was reported to us by staff that, "Consultants often do not use it, or use it in a way that seems to be aimed at getting others in trouble." Another comment made to us was that reporting was perceived to be other people's responsibility, particularly at consultant level.

The reporting system through Datix showed that themes and incidents were discussed at multidisciplinary meetings based on the event and not individuals, which helped in avoiding blame. If immediate concerns were identified about particular member(s) of staff, these were said by staff to be followed through by the line manager; in the case of a midwife, they would also be escalated to the contact supervisor of midwives (SoM). We were told that sometimes incidents were not registered through the Datix system, which meant that there was a risk that some incidents were not subject to the same level of review. Where incidents were not reported via Datix, staff said the management team required information in writing. However, staff said, the culture was of not wanting to put information in writing as staff did not want a 'witch-hunt'. This presented a risk

that incidents may not always be reported and, further, that information related to an incident may not have all the necessary information to assist in carrying out a full and objective review.

We were told by senior staff that the care group had a risk lead consultant for maternity who investigated any possible serious untoward incident involving the clinical director. The risk team included two clinical governance leads, one for obstetrics and one for gynaecology. , and the CNST / Audit midwife.

Learning and improvement

Comments made to us by midwifery staff in relation to safety included there not being a clear plan of action for midwives and obstetricians in respect of serious untoward incidents (SUIs). It was felt by some that there was a lack of joint review of incidents, of shared consideration of what to do, and discussions about who should be involved in making improvements and then measuring the outcome. Capacity for delivering statutory supervision of midwives had been enhanced, but there was a lack of joint working between the SoM and trust investigations.

A significant number of midwives reported a lack of multidisciplinary shared decision making. It was said that obstetricians were not prepared to take responsibility and midwives didn't feel safe with some of their decisions; these included decisions about when to intervene in the management of a delivery because of problems with misinterpretation of cardiotocography (CTG) recordings of the fetal heart rate during the second stage of labour. Midwives reported inconsistencies between consultants and between those who were in senior positions, and that decisions were made without reference to evidence-based guidance or policies.

Trainee medical staff expressed concern that some incidents were not being investigated as they involved a senior consultant, and that the consequences of investigations were variable in terms of who was involved. Staff reported that discrepancies in swab counts during operating procedures had been covered up. Surgical procedures required that various safety checks were made during and prior to completion of the operation. This included counting the numbers of needles and swabs to ensure they tallied with the numbers at the start or added during the procedure. Where discrepancies were found, all possible measures were expected to be taken to allocate missing items in order to prevent harm to the patient.

The trust had also used independent expertise to review a cluster of serious incidents for transparency and objectivity and we saw information to demonstrate that these reviews had been conducted fully, with lessons learned and recommendations provided to the trust. Some medical staff said they did not know what the outcomes were from this review and therefore did not know what learning could be taken from the review process.

Midwives reported that the reason for unplanned caesarean section was not being consistently and independently reviewed and that the person who performed the procedure often undertook the review in order to 'self-justify'. They understood that the review process was supposed to be undertaken on a twice-daily basis but this was not regularly happening, despite discussion with management and an agreement in principle. We were told by midwifery staff that a morning meeting took place each day in which caesarean sections were reviewed. This involved collecting the patient notes and reviewing them with a consultant, matron, the practice development midwife, and supervisor, if available.

We asked a member of staff if they would be happy to have a baby at the hospital and they responded: "No, unless I could chose the staff, the doctors and midwives." They added that they had no particular concerns about not being safe or trusting. This was more about the attitude of some and being able to stand up to some about what was right, but "something needs to change". Other experienced medical staff reported care being safe only because 'defensive practice' was happening on the labour ward. Safety was said to depend on who was on duty and it was difficult to raise concerns. Major concerns had been minimised depending on who was involved. For example, a post-operative bleed following a hysterectomy was classified as a minor incident when it was more serious than this. In another situation, a woman bled after a colposcopy and the report was said to have been written before the actual investigation had been fully reviewed.

Systems, processes and practices: Safety practices

We were told by staff that they had regular emergency drills on ward areas in order to maintain and improve their response skills in the event of emergencies. We asked to see an example of the drills carried out and we were provided with evidence of a skills drill in relation to the collapse of an expectant woman. This had taken place on

26 January 2014 and had been recorded electronically. We saw that information recorded included the lead person, attendees, analysis of the exercise, positive feedback and any learning from this.

We were informed that midwives had access to supervisors with a ratio of one supervisor to 15 midwives. The Nursing and Midwifery Order of 2001 sets out a statutory requirement that all midwives be subject to supervision. Supervision provides an opportunity for reviewing best practice so that the care of women and babies is safe. Supervisors actively promote best practice, preventing poor practice, and intervening when there are unacceptable standards of practice.

Systems, processes and practices: Monitoring processes

There were systems in place to monitor key performance indicators (KPIs) in relation to various safety and quality indicators in each of the maternity areas. A report provided to us for January 2014 indicated that the labour ward KPIs for the care of women during labour achieved 100%. Safety equipment checks achieved a score of 95% and risk assessments around venous thromboembolism evaluations (VTE) (this is a risk assessment for blood clots) achieved 94.7% compliance by staff.

Systems, processes and practices: Consultant practices

We identified potentially unsafe practice in regard to staffing 'high-risk antenatal clinics' with junior doctors. An example was given to us where 29 pregnant women were due to attend the clinic and there were only two junior doctors to manage this service. This arrangement could present a risk to the safety of women as junior doctors may not have sufficient knowledge and expertise to identify and manage complications. However, junior doctors had access to senior consultants for advice and guidance as well as within their supervisory arrangements, which would have minimised risks.

We looked at information provided to us from the maternity dashboard which showed that the weekly consultant cover on the labour ward was 98 hours. The RCOG (Royal College of Obstetricians and Gynaecologists) published a report in 2007 stating that for units performing between 4000 and 5000 deliveries per year that 98 hours are adequate. Consultant cover included the hours of 8am to 10pm and on call through the night. Three daily consultant-led board rounds took place on the labour ward, at 8.30am, 1.30pm, and 9.30pm. These rounds provided an opportunity to review the needs of women and to discuss any concerns with medical and clinical staff.

Monitoring safety and responding to risk

Maternity services had a dashboard that was used to monitor performance in regard to activity, patient safety and the workforce. The dashboard had benchmarks for activity around births, and both emergency and elective caesarean section. A traffic light system was being used to score the outcomes each month in relation to births, which was set at an annual benchmark of 5,200. Of these, we were able to see that in regard to elective caesarean section (LSCS) the benchmark level was set at less than 11% and scored a red rating of 13.9% for November 2013 and amber score of 11.6% in December 2013. Emergency caesareans scored red for November, when the rate was 18%, and for December 2013, at 20.4%, against an expected rate of less than 14%.

In relation to patient safety, we saw that red scores had occurred for two separate risk management indices during the last quarter of 2013. In October, three women were admitted to intensive care, against an expected number of one. In December, 28% of women experienced induction of labour against an expected rate of less than 22%. A high induction rate is often related to a high emergency caesarean rate unless there is appropriate staffing and capacity in the system to ensure that women get the right care at the right time and in the right place. If there were not enough staff or there were too many women already in the labour ward, women who were induced might have been delayed in being transferred to the labour ward from the induction suite or antenatal ward and therefore would not get one-to-one care at the right time in their labour.

Staff had access to a safeguarding lead and guidance on safeguarding vulnerable people, including both adults and children, accessible on the trust intranet. An alert system was in use that informed staff of any admissions to the department where they needed to monitor the woman and/or their new baby and there was involvement of external agencies as part of this process.

Cleanliness and hygiene

We made observations of the environment in which women were receiving their care and found all areas to be

clean or in the process of being cleaned as part of the daily schedule. A comment made to us by a woman who had been an inpatient for a few days was that "the cleaners have been great – thorough, kind and cheerful".

Staff had access to hand washing facilities and hand gels were prominently displayed both at the point of care and in various parts of the ward areas, including on entry. Staff were observed to follow good practice with regard to uniform and dress code, being bare below the elbows and wearing only permitted jewellery. We saw staff wash their hands or use hand gel between care delivery.

Staff had access to procedural guidelines and policies relating to infection prevention and control, although we noted some of these were out of date. This may have meant that staff were not always following the most up-to-date recommended practices. We did, however, see staff undertaking their duties in accordance with some of the expected safe practices, for example while handling and managing the different waste types, in their use of personal protective equipment (gloves/aprons), and when disposing of sharp items, including needles.

Infection control audit outcomes were displayed on noticeboards for the month of January and indicated that there was a high level of staff compliance with practices such as hand hygiene.

Anticipation and planning: Staffing

In all ward areas we visited we observed that there appeared to be adequate staff available to enable prompt response to calls and provision of treatment and care needs. We were made aware of the problems in filling staff vacancies and the impact that this had on covering all shifts.. Measures to resolve these recruitment issues were discussed with us, as were the future plans. The midwifery co-ordinator on the labour ward had oversight of daily duty rotas and at 3pm was responsible for reviewing staffing and activity levels and anticipating needs for the following day. We saw a 'daily staffing crib sheet' for 13 February 2014 that identified staff as midwives, registered general nurses, healthcare assistants and midwifery support workers and nursery nurses. The area of work for a worker was identified, as was whether they were contracted or temporary bank staff or supplied by agency. We saw that work had been completed around workforce use by area in January 2014. Information supplied and presented at the governance group in respect to the labour ward and the triage area showed that, during January, 71 shifts had been covered by agency staff; the majority related to sickness or unfilled shifts. We were provided with duty rotas covering December 2013 to February 2014 and saw the arrangements made to cover shifts safely, using contracted staff, with agency or bank staff filling any gaps.

The maternity dashboard provided to us showed that the workforce was monitored in relation to staffing ratios: for example, the ratio of midwives in contracted posts to births. We saw that the benchmark was set at 1:34; during the last three months of 2013, the ratio achieved for October was 1:31, November 1:28 and December 1:32. This was further reduced across all three months when they took into account bank and agency staff, with figures ranging from 1:25 at the lowest to 1:29 at the highest. These ratios, with the inclusion of agency staff, comply with the recommended safe staffing ratios for maternity units. However, the service would benefit from increasing the substantive midwifery complement in terms of continuity of care and quality.

This information supported a comment made to us by a consultant who said they had to cover the main theatres as well as the labour ward theatre, which was a potential safety concern.

Are maternity and family planning services effective?

(for example, treatment is effective)

Requires improvement

Maternity indicators

According to the data we collected prior to our inspection the trust had a similar profile of delivery methods compared with national counterparts. However this data was from 2011-12 and intelligence we gained from our external stakeholders and information provided by the trust showed that the trust currently had a higher number of caesarean sections. The most recent score (January 2014) indicated a rate of 35.8% with a KPI of 23.5%, which is significantly above the national average. This high level reflected what we were being told by staff. We did not see any action plans to demonstrate the measures to be used to identify reasons for lower scores or what action would be taken to improve KPIs. There can be a myriad of reasons for why this was the case – the most important issue is

whether a trust had first identified the problem (which it had) and had developed an action plan in response (for which we were less assured). In addition, women who had a surgical procedure tended to stay longer in hospital and needed more pain relief and higher levels of support with breast feeding. There would be an increased risk to mother and baby in subsequent pregnancies.

Using evidence-based guidance

Staff had access to policies and procedural guidelines that had been written in line with best practice guidance and research evidence. For example, we looked at a randomly selected policy for 'Bladder care: intrapartum and postoperative' and saw this had been written with reference to the National Institute for Health and Care Excellence (NICE). Some policies were highlighted as having been updated; however, other policies were not up to date and in some cases had not been reviewed as expected in 2010. An example of this was the policy entitled 'Use of the pool in labour'. The guidelines for treatment of an ectopic pregnancy in A&E and in hospital were due to have been reviewed in July 2011. Haemorrhage guidelines, written in 2010, were due to be reviewed in December 2013 but had not as yet been updated. The risk of out-of-date policies and procedures is that staff may not have access to the most up-to-date safe practices and research evidence to guide them in delivering care.

Staff, equipment and facilities: Facilities

We toured the maternity provision areas and found that the antenatal area offered a recently re-painted environment of four or five bedded bays, with access to a kitchen area and waiting room.

The labour ward had not recently been refurbished completely but staff commented on improvements that had taken place. . There were 10 rooms, some of which had ensuite facilities. The theatre was appropriately signed and organised to provide a safe environment.

The postnatal ward had recently been refurbished and comprised of 25 beds and five side rooms for examination of the neonate and for breastfeeding in private.

The midwife-led Isis birth centre provided single room facilities with access to birthing pools and contained necessary equipment to support the women in labour and for the immediate care of the baby after delivery. The triage area was found to be very cramped with limited space around the three cubicle areas. Privacy was therefore an issue. Staff also commented on there not being a central monitor in this area, which meant that CTGs may go unnoticed, resulting in women not receiving timely response to changes in CTG.

The outpatient service comprised a common waiting reception shared between maternity and gynaecology. The environment was dated and consultation areas were not fit for purpose. For example, only those people seeing the consultant were able to sit for the consultation before and after being examined. Remaining attendees were called into cubicles by the doctor and straight onto the couch, and from there they then left the examination cubicle. This impacted on people's privacy. The outpatient area would benefit from a redesign to provide an improved and responsive patient experience.

Staff reported the lack of a high-dependency unit on the labour ward as being something that needed to be improved, as women were currently transferred to ITU. Having high-dependency facilities on site would improve the continuity of care for women and their families. We were told by staff that ways to develop this were being actively explored.

Staff, equipment and facilities: Staffing

Staff working in the antenatal clinic said they felt pressurised as only two midwives were allocated to be on duty at each clinic. They said they were expected to book dates for women requiring elective caesarean sections or induction of labour and make appointments for women attending the vaginal birth after section clinic.

Staff working in the ultrasound area of the antenatal clinic reported being "stretched beyond the limit" due to high patient numbers. Staff were said to have developed repetitive strain injuries and found it hard to access occupational health or physiotherapy for appointments. The clerical area in the antenatal department was overcrowded and very congested. Staff reported that health and safety staff had carried out a recent visit to this area but we did not see any feedback from this.

Staff, equipment and facilities: Training

Trainee doctors told us it was a good place to work with opportunities to learn from a varied case mix. Positive feedback about staff engagement and support was made by a newer member of the midwifery team. They had a named preceptor who supported them through their personal development plan. They reported that they had

been booked on various training sessions, such as intravenous infusions, and had also completed mandatory training before starting their full-time role. This person was able to describe procedures relating to escalating concerns and complaints. They said they "loved the job" and felt valued by the midwives. They considered the matron leads and postnatal team to be approachable.

We asked senior staff if there had been a general training needs analysis. The response was that training was reviewed every six months for doctors and would sometimes be part of Practical Obstetric Multi-Professional Training (PROMPT). A training needs analysis was provided to us for maternity services and we saw that this identified subject matter, frequency, those expected to attend, and whether updates were required. We saw that there was an expectation for mandatory training to be undertaken by obstetricians and anaesthetists, including annual attendance at, for example, vaginal breech delivery and electronic foetal heart monitoring, as well as in recognising severely ill pregnant women. Training attendance was said to be mapped to the electronic record for midwives but for doctors there was no such system set up as yet. When staff did not attend, this was followed up by line managers. A named person within the medical team was said to hold the training records for doctors. To overcome the difficulties of compliance in attending, the doctors' rotas were said to identify who was on training and each person had to sign their attendance at respective modules. A meeting had been held with consultants to discuss leadership issues, and expectations in regard to training were discussed at this.

We were provided with information that demonstrated the range of training available to support staff skills and develop further competencies. For example, we saw that training was provided in parent craft and in sick/deteriorating women (sepsis skills training). We saw that PROMPT skills station training took place in respect to eclampsia and cord prolapse, breech deliveries and other complications or safety areas. Clinical-led study days covered such topics as mechanisms of labour, abdominal palpation, pre-eclampsia and eclampsia. A study day had taken place in January 2014 on high-dependency care in maternity. We saw good examples of the issues covered, such as the early warning alert system used to monitor women in labour.

Training figures for consultants showed that areas covered included resuscitation, infection control, medicines management and equality and diversity. Other training was accessible through such arrangements as 'Third Thursday Teatime Training', which were sessions arranged by the practice development team. Recent sessions had covered water births and venepuncture and cannulation (taking blood from a person's vein and inserting a needle into a vein).

We saw a good example of practical training being available to staff, with staff having access to the simulation and resource training room, where they could receive training on 'SIM MOM', an interactive pregnant dummy.

Staff, equipment and facilities: Equipment

We observed a good range of equipment available to support midwifery and nursing staff to undertake routine observations on women receiving care and treatment. Equipment had been checked to ensure it was safe to use and was suitably clean. We observed that daily checks were carried out in bay areas on the postnatal ward, assessing such standards as those around cleanliness, provision of oxygen and suction, clean linen and equipment.

Multidisciplinary working and support

We observed the postnatal ward to have a friendly atmosphere with doctors and midwives working well together. Staff said at the time there was a healthy atmosphere. We saw good multidisciplinary working in evidence on the labour ward and in the antenatal area. The Isis birthing centre was seen to be well-led and presented a happy and relaxed environment. The matron was said to have made a positive impact on the working relationship through their leadership style on the labour ward.

Staff told us they could access the vulnerable women's team, known as 'Crystal'. The team had direct involvement in the care and welfare of women as soon as pregnancy was diagnosed and continued the care after delivery. We saw in one person's care record we reviewed that it did not identify any plan in place to manage the person's potential health needs, despite the individual having a previous history of postnatal depression. We could not be certain therefore that arrangements had been made to identify, monitor, and manage such a situation if this arose for this person.

Inadequate

Maternity and family planning

We were told that other support required for women may include the dietician or tissue viability nurse. The latter could be arranged by email contact or telephone.

Are maternity and family planning services caring?

Requires improvement

Compassion, dignity and empathy

The trust scored 'about the same' as other trusts in all aspects of the maternity survey (split into three sections, labour and birth, staff and care in hospital) as other trusts in England in the CQC Maternity Survey 2013.

Staff treated people using the service with respect, in a caring manner and with attention to maintaining their dignity. A member of staff was heard discharging a woman from the postnatal ward in a manner that was kind, compassionate, and responsive to their questions and needs.

We spoke with new parents and the following comment was made: "Excellent care and communications from the midwives and obstetricians." Particular care needs were said to have been identified at the initial booking and care was shared between the GP and the obstetric and perinatal mental health teams.

A new father told us the experience of the maternity service had been very good and staff were "excellent" there.

We reviewed information completed via an online patient experience survey; this indicated some negative comments about the experiences women had regarding dignity and respect, for example in the case of midwives' attitude towards a woman who had post-delivery vaginal bleeding. Women reported not being told of a procedure to remove blood clots and not being offered pain relief. Another woman reported not being allowed to have their partner stay after their caesarean section. One women reported the "grumpy" attitude of a midwife on night duty and how their attitude was one of "what do you want?" when the woman sought advice.

One of the comments made was that "the night team was awful and one obstetrician who saw me just kept raising objections as to how I couldn't have a water birth and made me feel awful". We saw a comment in respect of the staff team that stated: "Some midwives were great; others looked exhausted or not bothered."

One woman using the antenatal service commented that the service was satisfactory and also said: "I have no complaints really but I'm just starting here." Another comment made to us by a lady attending antenatal was: "It's not amazing but it's ok." They added that they would recommend the service to other women.

One woman described her negative experience when a receptionist had a "couldn't care less" approach towards them. They added that "staff were friendly today".

Involvement in care and decision making

People who had received care from the maternity team said they felt fully involved in decisions and they would be "very happy to recommend this unit".

We spoke with a pregnant woman who had particular physical needs, and she said she had to keep reminding the midwives caring for her about this. She had to request on several occasions to meet the anaesthetist and "has finally been referred" but didn't know when she would be seen.

We tracked the care records of seven women who had delivered their babies.. We found that all records included essential information such as their demographics and where the person required additional support or care in respect to their care needs. Birthing plans were in place in two out of the seven we reviewed. Where caesarean section was planned or undertaken as an emergency, we saw recorded information for each stage of the surgical procedure, including pre-operative preparation and care and aftercare needs. Risk assessments were identified and completed. We saw, too, that pain assessments had been carried out and we saw evidence of the involvement of the physiotherapy team with respect to post-delivery exercises.

A comment made via the online survey was that: "They completely disregarded my birth plan and raised objections." However, another comment was: "Extremely impressed. Stayed in the Isis maternity ward and cannot recommend the staff highly enough. Professional, approachable and made me feel as comfortable and looked after as possible during the birth of my child."

Inadequate

Maternity and family planning

Trust and communication

In the majority of cases we found that staff had developed trusting relationships with women and their partners who used the service through, in the main, good communication and respect for their needs. Staff were open and honest, and also sensitive to individual patient needs and circumstances. Patients commented that they had sufficient information in order to make an informed choice about their care and we saw that consent had been sought for surgical procedures of both elective and emergency caesarean sections.

In one situation, poor communication between the community and hospital antenatal services was a contributory factor for a woman who had been diagnosed with gestational diabetes being "uncertain about plans" for appointments or their pathway.

Friends and family comments were displayed prominently on the postnatal ward and responses were seen to be very positive with regard to staff support, their caring nature, and the provision of information. For quarter 3 in 2013/14, the trust had 64 responses out of a possible 436 in respect of the maternity service, with 35 respondents extremely likely to recommend the hospital and two extremely unlikely.

Emotional support

One woman attending an antenatal clinic about a medical condition said that they had "great problems in understanding the doctor's English". They added: "Fortunately, the nurse saw we [herself and her partner] were confused and stayed behind to explain."

A woman who spoke with us on the postnatal ward said they were "well supported emotionally". We saw bereavement guidelines that did not suggest to the reader that there was access to a midwifery bereavement specialist. However, we saw that staff had had access to a bereavement study day, last provided in December 2013, which covered such areas as communication skills, models of grief and parent views. We saw evidence that 19 members of staff attended this training, which demonstrated that the trust ensured that staff were given access to relevant training.

Are maternity and family planning services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

We found that the maternity services were not always responsive to people's needs.

However, feedback from a comment card indicated that the respondent received an excellent service from the maternity department, staff were described as "excellent", and they had written "there were no problems". One person had expressed a negative comment that there was no clock available in the antenatal waiting area.

A woman who spoke with us explained the poor experience she had had as a result of lack of communication between the hospital where she was due to give birth and her community midwife. She had been required to return three times to Wexham Park for Down's screening as her blood test results had been lost on the first two occasions. She was informed on the third visit that it was too late for the test, which caused "so much anxiety". We looked at the staff guidance for Down's syndrome screening and saw that there was a clear pathway to follow, commencing at first contact with the GP or community midwife, where an appointment was expected to be made for screening at eight weeks gestation. A scan is indicated to be performed at 12 weeks or for dating purposes prior to 11 weeks. The information described to us indicated that the pathway was not followed on this occasion.

Another area where this individual's needs were not recognised and addressed promptly related to gestational diabetes. Although she had informed her community midwife of previous gestational diabetes, she had been advised to eat foods to increase her blood sugar levels. Her condition had been diagnosed by Wexham Park during her antenatal screening and prompt referrals made to a specialist clinic. The woman felt that improvements could be made in communications between the community staff and the hospital but also that phone, email, or text should be used for speeding up the appointment booking process. Overall, the woman using the antenatal service said the service was "ok".

Maternity and family planning

Food was described by one person as "rubbish" and not being fresh, although there was choice. Food was described as "not great", and what you "would expect for free food" by another person.

Women were given written information to support verbal discussions. For example, a leaflet could be provided on the 'latent phase of labour'. In addition to breastfeeding leaflets, we saw a range of laminated information sheets available to ladies on the postnatal ward. These were in Urdu, Punjabi and Polish. Staff said they could be given to women to read or to be photocopied. Staff could also access other leaflets via the internet.

Vulnerable patients and capacity

We found in our discussions with staff that they felt well trained for safeguarding vulnerable people. They told us there was a dedicated 'Crystal' team for vulnerable people coming into the service. This team was midwifery-led and would be involved in supporting people who may have learning needs, for example. Staff on the ward said they had good support from this team. Staff said they had received training on communication skills to help them meet the needs of those who were more vulnerable.

Access to services

Parking was described negatively by numerous people who spoke with us, including the costs. One person said: "Parking is terrible." One person in the antenatal area said waiting times were generally "too long", although they had easy access to appointments. A receptionist who was rescheduling appointments commented to us that not many clinics were cancelled and rescheduling was not usually triggered by the hospital but made at the request of the women. They also told us that it was easy to pre-book interpreters and that there was a reliable service, but many people brought their own interpreters. Staff and women using the service told us they could access an interpreter easily if required, although staff did say that often an interpreter was male. Two ladies in the antenatal area whose first language was not English reported that no one had offered them an interpreter and one said she could not "always understand staff".

We were told about the positive ease of access to care, including appointments, and one lady said they had "felt well informed" and had been given written information. A tour of the unit had been given to one person who spoke with us. They said the parent craft was "very informative" and they "felt more confident".

Women had a choice about delivering their baby in the Isis birthing centre, rather than in the main labour ward or at home. Access to this service was through ward-based triage based on a risk assessment or via community referrals. These arrangements meant that all risks were fully considered before admission and that alternative arrangements could be made in discussion with the women where risks were too great.

Leaving hospital

Overall, there were effective arrangements for the discharge of women and their babies. However, on occasion there were delays in discharging women, as staff said that discharge arrangements were dependent on the availability of a consultant to review women who had had a caesarean section. They tried to minimise delays by having pharmacy items ready. There was also no current neonatal trained midwife to discharge babies, which meant that such discharges had to be made by the paediatric SHO's. .

Another matron described how they felt that consultants were not interested once the birth was over. They said it was often difficult to get the consultant to review the women post-caesarean section and prior to discharge. Women had to wait around until consultants had a "lull in labour ward work". This added to delays and had a knock-on effect on bed capacity.

Despite these comments, we heard midwives preparing women, their partners, and their babies for discharge home from the labour ward. Staff provided information and guidance in their discussions. We saw that a red book entitled 'My personal child health record' was given to new mothers to take away. We also saw in the case records we reviewed that the discharge process was planned for, with information provided to the person's GP and community services so that ongoing care was arranged.

Learning from experiences, concerns and complaints

Not everyone we spoke to knew how to make a complaint if they were not satisfied with their care. Leaflets were seen around the wards and hospital. . Information was visible in some areas, including the labour and postnatal wards, for anyone who used the service and who wished to contact the Patient Advice and Liaison Service (PALS).

Inadequate

Maternity and family planning

We saw displayed on noticeboards in ward areas feedback from people who had used the service, such as "needing more support with breastfeeding". The action taken by staff was stated. In this case, more volunteers had been recruited to assist with supporting women.

Patient feedback was discussed within the quality and safety report for areas. We saw within the report for labour and triage that common themes for January 2014 were expressed by patients, such as "couldn't have done it without you" and "the whole team was very supportive". Themes and trends from complaints were reviewed at the specialty meetings, and areas of concern were escalated to the relevant staff to ensure that they could be discussed and acted upon.

Are maternity and family planning services well-led?

Inadequate

Vision, strategy and risks

We asked the members of the senior clinical team what the main priorities were for the provision of a quality maternity service and they said: "Reducing the caesarean section rate"; they were aware that this was higher than the national average. The rate had previously gone down to 24% and was now at 35%. All caesareans were said to be discussed at the incident review group and presented at monthly meetings in order to keep the matter on the agenda and "keep the focus".

The clinical director for maternity said that all consultants were aware of what was going on in regard to serious incidents. We asked if feedback was timely and evidenced-based and were told that "yes", this was the case for midwives but not necessarily for doctors, although there would be an overarching action plan and the "obstetric steering group monitored action plans monthly".

We discussed ward-based risk management with the senior team and they expressed a worry regarding risk monitoring in that there was heavy reliance on the midwives and nurses, which was said to create tension between the respective clinical groups. Midwives were feeling uncomfortable about having to monitor consultants.

However, it was said to us by the senior team that the midwifery team was strong and focused on what was right for women and the service. This was seen to be a positive attribute of the midwives.

A matron commented on the lack of engagement around plans to reduce the staffing levels in labour wards. The staff member first became aware of the reduction when they submitted off-duty rotas and had them returned with reduced staffing. This was said to be because birth rates had gone down. However, staff said that many women required a lot of support and the caesarean section rates had increased, which meant more direct care was needed. There was a concern that staff cuts would take place and of how this would impact on care delivery.

Governance arrangements

We asked senior staff how reporting upwards worked. The lead for nursing said she had lines of accountability; the management line through to the Director of Operations and the professional accountability through to the professional lead such as the Director of Nursing for professional nursing and midwifery issues. There were quality assurance panels throughout the month. Reports were sent to respective managers in accordance with a quality and safety pack. There were also one-to-one meetings with the director of nursing. There was no representative from the senior group at the Health Care Governance committee but it was expected that this would happen in the new division. However, during the inspection it was not clear what impact the new divisional structure would have on the service.

With regard to the trust board, we asked if there was a non-executive director with an interest in maternity and were told that there wasn't such a representative. However, we were told that the board was aware of governance matters through the risk summit, where only maternity services and issues were discussed. The acting director of nursing was also a voice on the board for midwifery and nursing.

Leadership and culture

We found that there were mixed opinions as to the leadership within the maternity department; in most cases comments reflected dissatisfaction and concerns about certain leadership practices. We received numerous expressions of concern about the leadership style, and in

particular about the separation between those doing the work and those making the managerial and clinical decisions. Staff stated that they felt "disempowered" and distanced from the decision-making process.

Leadership and culture: Perspectives from senior clinical staff

Senior clinical staff told us that they had not felt supported by the existing divisional structure, and did not have enough opportunity to discuss this with the board. It was felt by these individuals that this would be improved once the division became separated into the 'women's and children's division'. The three senior staff said they worked alongside each other in a challenging environment. They met weekly and felt they provided a clear voice, for example on changes in the directorate. They indicated that the structure beneath them had not changed, which made it quite challenging to do everything. Whilst the clinical lead expected challenge, they indicated that there was initially a lot of support from the chief executive but little other support. They added that it had been difficult at times to get people to do what they had to. We were told that: "It was shameful that I had to explain through a document" (which was signed in agreement) an expectation to be at clinics on time. Overall, the senior team felt that the majority of consultants were doing what was expected of them and presented a positive message of leadership and support to the junior doctors.

In our discussion with the senior team, team members indicated that dealing with job planning was creating a lot of tension. They said it was difficult to judge if the behaviours in trying to tackle this were appropriate, but added, "clearly the trust has not had a transparent response to bullying concerns" which was impacting upon being able to job plan effectively. The medical director was said to act as arbitrator when agreements could not be made in respect to job plans.

We asked questions of the senior team in regard to other tensions, including any issues regarding ethnicity. We were told that there were some "tensions" around who was appointed as the lead for governance but apart from this the only issues experienced had been comments about "favouritism" rather than ethnicity. The team said it tried to be open and transparent, with all jobs advertised and clear scoring criteria.

Leadership and culture: Doctors' perspectives of leadership

A member of the medical team said to us that it was "difficult to work where there is a culture of blame and non-transparency". They were not sure where messages came from and described how, when rules were changed, they did not always know the reasons why. For example, a decision was made that senior house officers could not carry out a vaginal examination using a speculum to carry out a speculum examination. This was communicated at a departmental meeting but no reason why was given. Despite trying to find out the rationale for this, the doctor had not been successful. They thought it may have come from an adverse event where two vaginal examinations had been carried out to assess a woman's condition. The doctor added that the Royal College of Obstetricians and Gynaecologists guidance was that such an examination was acceptable as part of the assessment process.

We were also told that communication from "the top down was poor". An example was given where doctors prepared a presentation to be shared with other medical staff at the clinical training group only to turn up and find that the planned session had been cancelled. Although they were informed that an email message had been sent out to advise of this, the doctor reported that this had not been received.

Medical staff had experienced inconsistent approaches to investigating incidents. In some cases this involved the suspension of senior staff pending investigation, when early substantiation of information would have provided evidence that the individuals either were not involved or were undertaking other duties within the hospital at the time.

Some experienced and senior medical staff said they had been stripped of additional sub-specialties, which was demoralising. Senior staff reported being 'career blocked' for a number of years and being "systematically bullied".

Other medical staff said they had perceived an atmosphere of bullying and intimidation, with an example cited in relation to a 10-minute rule for arriving late at CTG meetings. The rule was said not to be applied fairly and staff had been turned away despite making every effort to be present before the 10-minute rule applied. Trainee

doctors said they had also raised issues of bullying with the deanery. Other staff reported that they were asked to remove information from statements and that threats of the sack had been made to them in meetings.

Leadership and culture: Midwifery perspectives on leadership

Midwives commented on the visibility and positive communications from the chief executive but said that senior managers and matrons were poor in communicating. For example, they expressed concern that no discussion had taken place regarding potential staff cuts on the labour ward because of the reduced number of births. Senior managers were said to be unapproachable and 'top-down' communication was not working. Managers were said by midwives to be "controlling" and not open to suggestions. Midwives expressed that there was a lack of support from consultants towards the registrars when they worked on the labour ward and we were told that registrars were lacking confidence in their own decisions.

While some midwifery staff reported having approachable line managers, others reported a bullying attitude by some staff, with, for example, comments being made behind their backs when staff had been approached for advice. They described a "clique", with supervisors also being part of this. It was stated to us that the head of midwifery was doing what she could but staff were fearful of raising issues with the managers and supervisors. Staff cited examples where they felt they were not treated with any compassion. For example, they were given limited time off of only half a day following the death of a close relative. Staff said they had been discouraged from attending focus group meetings with the CQC inspectors and one was told "not to go". Other staff reported feeling "frozen out of meetings and opportunities". Two midwifery staff said they felt "discriminated against". Staff reported being rostered to work at times when social functions had been planned, so they could not attend.

Leadership and culture: Human resources

Midwifery staff said they had experienced procedural actions taken by senior staff in conjunction with the human resources department (HR) that did not reflect fair and equitable practices that would be expected in an organisation. For example, during disciplinary hearings, staff reported being directly questioned by the investigator. We reviewed the trust disciplinary policy and noted that, while it provided information as to the role of the investigator, it did not make it explicitly clear that they would not be able to ask direct questions of the person or that any questions should be raised through the chair.

Another example cited to us in regard to HR was the public posting of an advert for a senior position before the individual holding the post had been told they were having their position terminated. Other practices that staff felt did not represent a fair and supportive system included lack of reasonable adjustments to allow an employee to return to work after a period of sickness absence.

Decisions about suspensions were said by members of the senior team to be made by the medical director and chief executive, rather than by them, although they said they would offer clinical advice. We discussed procedures for managing conduct and capability with senior staff and were told that normal trust procedure was followed. It was said that they sometimes struggled with HR advice, "as there was a fear we couldn't manage doctors' capabilities". Advice was now available from 'Capsticks' solicitors and was said to be more "robust" but it remained "a tortuous process". We were informed that the trust had recently had a review of the disciplinary policy.

Patient experiences, staff involvement and engagement

We were told that consultants all had appraisals but there were some questions around their effectiveness. It was not known if those who were carrying out the appraisals were trained to do so. Although some consultants were said not to be putting their private practice in their appraisals, the clinical director was confident that consultants were getting yearly fit-for-purpose appraisals that would meet the requirements of the General Medical Council; however, we were not provided with evidence.

Positive comments made by midwifery staff related to the friendliness of staff and the interesting and diverse communities they served. The translation service was said to be good and there was a range of translation cards available to assist staff. We received positive comments in relation to peer support and the practice development team from midwives. We had mixed responses to our questions about the 'Family and Friends' test, with some staff saying it was a good place to work and others saying they would not recommend the hospital.

Inadequate

Maternity and family planning

We saw information reported as part of the quality and safety update that indicated 'highlights' of the month. For January 2014, we saw that a 'staff member of the month' was named for being a consistent team player on the labour ward, and in triage a named individual was identified. Qualities described included a willingness to offer assistance and being relied on to "deliver care to a very high standard".

Learning, improvement, innovation and sustainability

Medical staff stated that they did not always feel that learning took place as a result of incident reviews. An example was given where information was not shared from a cluster of serious incidents that had been reviewed in 2013. Trainee doctors said they were not getting the chance to develop their skills in relation to caesarean sections, as there was a fear that if anything went wrong they (meaning certain senior staff) would be looking to blame someone. There was a general feeling that the most senior consultant worked in a way that apportioned blame to the less experienced doctor.

We heard from doctors that there was a weekly multidisciplinary clinical training group session where cases from the previous week were reviewed. Weekly teaching sessions for doctors were said to also take place for doctors in training, where broader topics were discussed. Academic half days were planned for each month. Consultants were said by doctors to be engaged in the training.

The trust had engaged a professional coaching agency to assist in improving internal working relationships. The response in regard to the effectiveness of this so far was that: "It was working with those who wanted it to work." The midwifery coaching had been seen as very helpful and junior midwives had "flourished".

Good

Services for children & young people

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

Information about the service

Children's services at Wexham Park Hospital were consultant-led and were located in the children's department, where surgical and medical admissions were accepted onto ward 24. Within the children's department, there was an assessment and a decision-making ward area, where children could be readmitted or transferred from A&E while awaiting a bed on the main ward. The separate children's ward had a room set aside for high-dependency care. Children and young people were admitted for a range of medical and surgical conditions, including oncology, mental health, general surgery, plastic surgery, ear, nose and throat (ENT), orthopaedics, urology and oral surgery.

Some day-case surgery was provided at the Heatherwood Hospital Children's Centre. In addition to the children's ward, Wexham Park Hospital also provided paediatric (ENT) and orthopaedic surgery on general surgical areas, where adults were also treated.

Wexham Park Hospital had a neonatal ward categorised as a 'local neonatal unit' (LNU) on site. The level of care provided within this unit allowed for all categories of neonatal admissions, with the exception of babies who required complex or long-term intensive care.

Outpatient services took place in a designated clinic in the children's department at Wexham Park Hospital. Some paediatric outpatient services were provided at Heatherwood Hospital, and they also took place at St Mark's Hospital in Maidenhead, at the King Edward VII Hospital in Windsor, in Chalfonts and at the Bracknell Skimped Hill site.

The trust had a children's community team based on site with eight senior nurses, including an advanced nurse practitioner for oncology/palliative care and diabetes and respiratory/allergy.

Good

Services for children & young people

Summary of findings

The treatment and care needs of children and infants were assessed and planned from referral to discharge, taking into account their individual needs and with reference to their parents. We found that children and infants received safe and effective care throughout the hospital.

Staff were aware of best practice guidance for the safe and effective care of children and infants. The health and well-being of children, young people and infants were monitored using recognised assessment tools. Children who spoke with us said that the staff were kind and caring and that they received information that helped them understand what treatment and care they were receiving. The majority of parents who spoke with us commented positively on the service, the quality of care, and how both they and their child were treated with dignity and respect.

Children received pain relief according to their needs and with prescribed medicines. Staff were aware of their responsibilities for safeguarding children and arrangements were in place for looking after vulnerable children and infants.

The service was not always responsive to the needs of children and young people. We found that the provision of culturally appropriate meals was not always discussed or offered and parents had to bring some food items in for their children.

We found that the paediatric services in the hospital were well-led by a very enthusiastic and committed team of staff.

Are children's care services safe?

Good

Safety and performance

Staff working in the children's services monitored and minimised risks effectively. A range of staff at different grades and positions were able to describe how incidents were reported on the trust based 'Datix' system. There was an expectation that all staff would use the reporting system, regardless of level of seniority or role and staff indicated in discussion with us indicated that they were confident in uploading and logging information. We found that all incidents, accidents, near misses and never events (mistakes that are so serious they should never happen), complaints and potential abuse matters were logged on the electronic incident reporting system.

We found that joint final review panel meetings were held to consider Datix incidents. A lead investigator was appointed and a clinical expert advisor was part of the team. We reviewed the process of one review, which included a summary of the incident, outcomes of the event, and the involvement and support of patient and relatives. A root cause analysis took place and information was shared with staff. The review process identified good practice, as well as impacting problems on the delivery of service, lessons learned, recommendations and conclusions. We saw that actions were taken as a result of the review and included for example, increasing access to named antibiotics and the update of the early warning risk tool, known as 'PEWS', with inclusion of training regarding the tool in doctors induction.

We reviewed information related to the admissions by birth weight/gestation to the neonatal unit and saw that for the period of 1st January and 31st December 2013: 567 admissions had taken place. With the exception of pre-term babies the highest admissions with a specified factor were for respiratory disease, jaundice, infection and hypoglycaemia (low blood sugar levels). As an indicator of safety we asked about the higher than expected admission rates to the neonatal unit. We were told by consultants that the rate of admission was between ½ and 1% higher than a comparative hospital, such as Reading. They were not sure of any specific reason but the population served in East

Berkshire was said to be different to a comparable district general hospital. Figures were noted by consultants to have been consistently higher in the Neonatal unit for a number of years.

We were also provided with information that demonstrated the Neonatal unit had a 'dashboard' which reviewed quality measures and processes. In respect to safety and quality figures indicated for December 2013 and January 2014 100% scores for observations of infants, the recording of their documentation and provision of names bands. In relation to light and sound scores achieved were 83% for both months and the storage of medicines had achieved 100% for January, an improvement on the previous months score of 75%.

The trust participated in the collection of comparative data for South Central Commissioning for Quality and Innovation (CQUIN). Information provided to us indicated that positive results were being achieved in a number of areas, such as parenteral nutrition (PN) by day three of life, whilst a red rating was given for PN for day two of life. Parenteral nutrition is nutritional feed given into the vein. We asked about the lower score for day two and were advised that babies on the unit were not necessarily sick enough to need parenteral nutrition early on and they waited to see how the baby progressed before commencing. For sicker babies in higher category units there would be an expectation that such feeds commenced earlier.

In addition the trust collected comparative data as part of the National Neonatal Audit Programme (NNAP) and we reviewed results indicating positive outcomes in respect to women having their first consultation within 24 hours, antenatal steroids having been given and breast milk at discharge home where a baby was delivered less than 33 or up to 40 weeks gestation.

Learning and improvement

Information from investigations of adverse events or incidents was said by one staff member to be shared in handovers and was communicated on a notice board in the staff room. A matron told us that incidents were reported and followed up by the lead nurse. If the incident involved a particular nurse they would get direct feedback. In addition information arising from the investigation was communicated through a message book, during handovers between shifts and in a safety brief. The coding of incidents was said to be completed by the lead nurse.

Consultants informed us that they held medical staff meetings, either before or after the academic half days that took place regularly. They also said that there were a number of shared meetings with the maternity services. The staff had acted on learning points from a serious untoward incident and the action taken to minimise recurrence had led to the production and sharing to staff of a protocol for managing septic arthritis. We were able to see the updated guidance for managing septic arthritis in children, which was available to staff on the intranet.

The top 10 reported incidents had been reviewed in September 2013 and learning points from this review had included improvements related to medicines and the ongoing monitoring of children's care. We were able to see that this included an update to the early warning scoring system used for, monitoring children, and known as PEWS. Age related PEWS monitoring tools were available to guide staff and were seen in use in care records we reviewed.

The Neonatal unit produced a 'flyer' leaflet for staff which we saw was informative in regard to incident learning and improving practices. We saw for example that information was provided to staff about late antibiotic administration and checking of formulary for Folic acid prescriptions. We saw also that staff were given an update on the flyer of the risk register and reminded about various procedures to be followed. This included incubator cleaning and blood test for Bilirubin.

We were made aware by email contact on the 12th February 2014 from the parent of a child that they had concerns about the way in which the post-operative care of their child did not go as expected. We were informed that as a result their child was transferred at their request to another hospital and needed emergency surgery. We discussed this matter with the lead for children's services and were informed that the matter had been reported via the 'Datix' system and was under full investigation by the clinical lead for surgery, as the pathway for this particular child admission and care had been unusual. Assurance was given that this would be followed up with the respective parents.

Systems, processes and practices

The children's service had its own risk register, which staff said was updated monthly and was accessible to staff on the 'shared drive' of the computer system. Risks were said by staff to be discussed regularly at the Paediatric Healthcare Governance Group. Risks were also said to be

discussed with staff at ward or senior staff meetings and the Clinical Practice forum. We reviewed the risk register and saw examples of ratings being applied to the risks identified, with a responsible person for leading on the risk, identified controls, action plans and a target risk rating. Information as to how the board would be assured and dates for addition to the register, last reviewed and next review dates were in evidence.

The children's departments had key performance indicators in place for a number of areas, including for example, the number of incidents, complaints, and in relation to equipment checks. They also looked at aspects of the workforce and infection control. We saw that information was collected each month; for example, we saw that in January the Neonatal unit had 16 incidents but no new or outstanding complaints. They had completed 100% of the necessary equipment checks and had 100% compliance with discharges at 36 weeks.

We were told that there were three quality reviews by matrons each week. Matrons walked around the respective areas and undertook a variety of checks. We saw that these checks included various aspects of children's care records, such as their assessment, care plan, observations by nursing staff, medicines. In addition various environmental checks were carried out, such as storage of medicines and equipment checks. The information was collected on an IT system known as 'Survey monkey'. Staff told us they had information shared with them following the review. They also said that information regarding their performance was shared after each handover between shifts directly at the information board, situated on the corridor. We saw that this board was populated with information about safety practices and feedback from people on the ward.

We asked senior staff about the arrangements for transferring patients from A&E to the ward, given the distance between areas. We had been told by senior consultants that there was a strict criterion for managing the patient flow between areas. However, when we checked to see if this protocol was available we saw that there was only a general policy for transfer that did not make reference to the needs of children. We raised this with nursing staff who advised us the new guidance was only in draft form, a copy of which was subsequently provided to us.

Consultants said the only impact on children's care was that the distance between ward and A&E was when they had to go to the A&E department. This meant at times they were taken away from clinical procedures.

Cleanliness and hygiene

During our observations of the immediate environment in which children and infants received treatment and care we found all areas to be suitably clean. Feedback from a comment card left on the children's ward was that the environment was safe and hygienic. A mother who was present with her child also commented directly to us on the good standard of cleanliness of the environment. Another parent commented that they had noticed small items of paper not being picked up off the floor, which made it appear unclean.

We saw that where cleaning was taking place, domestic staff were using colour coded equipment items for different parts of the ward, which meant that they minimised potential cross contamination. We saw that domestic staff as well as clinical staff had easy access to and wore personal protective equipment including gloves and aprons during various duties. Discussion with domestic staff confirmed that there was guidance to direct them in relation to the required cleaning duties and processes to be used. We saw cleaning schedules on display in some areas visited.

Hand wash facilities were easily accessible in all areas inspected, with guidance displayed as to the correct method to clean hands. We saw provision and use of hand cleansing products and provision of paper towels to be in good supply. Staff were seen to be bare below the elbow and the majority were observed using hand gel on entry to ward areas and between patient contact.

Infection control procedural guidance was available to staff on the intranet and we saw that staff followed guidance with regard to waste disposal, management of bed linen and disposal of sharp items, such as needles and the handling of specimens.

We were told by different grades of staff, including play specialist, support workers and nursing staff that they had infection control training on a mandatory basis, including within the induction. Training figures were provided to us and we saw examples of the subjects covered including infection control. Out of the 52 nursing staff on the

paediatric ward 44 had received this training as part of the updates; however, we could not tell from the information if the remaining staff were booked on their updates and when this would be.

We reviewed infection control audit results in relation to hand hygiene and saw that the expected target of compliance was set at a low level of 80% on the Neonatal unit. However, the compliance rate was exceeded, with a response of 90% for January. In December 2013 the results achieved were 100% for hand hygiene and general infection control and hygiene monitoring 100% with a target set as 80%. We saw an infection control action plan was in place with various objectives stated, the expected outcome, actions to be taken and target dates. Responsibility for delivery and accountability was clearly identified, as was the method to be used to collect evidence.

Infection control policies were accessible to all staff via the hospital intranet and we viewed a sample of these. We found that a number had not been updated as the dates indicated they should be. For example, 'Procedure on the isolation and Cohort Care of Patients'. This had been written in October 2010 and was due for update on 31 October 2013. Similarly the policy on 'Management of Infectious Episodes, Cluster and Major Outbreaks' were due for review on the same day. The absence of updated polices may mean that staff do not have the latest best practice guidelines to inform them in their duties and responsibilities.

We found that arrangements were in place to review incidents that related to infection control. The Neonatal department had carried out root cause analysis of a cluster of Adenovirus infection, which affected a number of babies and staff, with a resulting outcome of conjunctivitis (an eye infection). This occurred between April and May 2013 on the Neonatal unit. We saw that the process for reviewing this cluster was detailed and followed an analysis of events, review of good practice and actions taken by staff to minimise further risks, as well as lessons learned. This demonstrated to us that staff considered and acted upon safety concerns that involved people using the service in a timely manner.

Equipment

We found the Neonatal unit to be equipped with essential items required to support the care and treatment of infants. This included resuscitaires. This is equipment used to provide care and warmth to babies just after birth. Staff were observed using equipment to monitor the infants in their care. Staff were able to use an electronic record system 'BadgerNet live' that related to each infant and gave a visual oversight to location and any procedures that were taking place or were required. BadgerNet is a system that is in use in most Neonatal units.

The children's clinic was well equipped with scales, measurement devices and staff also had access to the departments own ultrasound machine. Staff on the children's ward told us they had been trained in the use of equipment and we were supplied with evidence of this training.

A play specialist told us that there was a sufficient play equipment to meet the age related needs of children, including teenagers and we saw that this was the case. They advised us if they needed more they only had to ask and they would get equipment. We reviewed a comment card from a patient who indicated that some of the technical equipment for their use was outdated, for example, there were no headphones for televisions. We saw that where similar requests had been made by older children, these had been acted upon. For example, some of the computer equipment in the teenage room had been improved.

We looked at equipment used for the support and monitoring of infants and children and saw that electrical safety tests had been carried out, that equipment had been serviced and was clean and fit for use. We asked staff in children areas if they had enough equipment to provide safe care and in general staff said this was the case. Staff did comment on the lengthy process to obtain equipment, such as general stock items. They attributed this to having to go through processes of costing. We noted that the risk register identified stock unavailability as impacting on the service. We saw that control measures had been put in place and that the risk was due to be re-reviewed at a speciality governance meeting to be held in February 2014.

We discussed the availability of equipment for supporting a child in the event that they needed ventilation support. The staff member told us that there was a transport ventilator available and if need be a ventilator from the neonatal unit would be used for a baby, prior to transferring to a Paediatric Intensive Care Unit. Staff said that these arrangements worked well.

The consultants said they had experienced difficulties in obtaining equipment, including such items of stationary. They said that there was no process mapping and it was difficult to get things through the existing procurement processes.

Discussion with medical staff indicated a degree of variation about the effectiveness of the IT system, with some saying it was good, although there was "no electronic prescribing in use." Others said that there were problems with the IT system "not talking to each other." It was also taking an excessive amount of time to log in. The consultants who spoke with us said the "poor system" meant that consultants had to "complete some audits manually as they could not be confident that information recorded was accurate."

Medicines

We saw that medicines in all children's/infant ward areas were safely stored and in accordance with effective medicines management. Drug charts reviewed in children's care records indicated that medicines were prescribed by doctors and that only staff who were trained to do so gave out such medicines. We observed nursing staff supporting children to take their medicines on the children's ward and saw that they stayed with the child to ensure the medicine had been swallowed or inhaled correctly. Signatures were added to drug records after medicines were given. Records of drugs given to children as part of the surgical procedure they had performed were also seen to be clear and accurate in respect to anaesthetic agents and pain relief. A child appropriate pain assessment chart was used by nursing staff in order to measure children's pain and manage this appropriately.

Staff had access to national formularies for guidance, as well as pharmacy support. We noted that temperature control of medicines storage units were checked by staff in the majority of cases. We were told by staff and noted on the risk register that the drug room on the neonatal unit was at risk of overheating which could impact on the optimum storage of medicines. Existing controls had been put in place including an agreement for the maximum temperature and that an air conditioning system should be put in place. There was no agreed date for the latter to be achieved by; therefore we did not know when this matter was to be addressed by.

Monitoring safety and responding to risk

We discussed the risk assessments used for children care and were told by a nurse that visual infusion phlebitis (VIP) scores were monitored when a child had a drip or cannula in their vein, and we were able to see that staff carried out the required monitoring on a teenager whose care records we reviewed. The same nurse added that urinary catheters were rarely used and that they were not aware of 'care bundles' for such devices. Care bundles are part of high impact interventions (HII) to ensure appropriate and high quality patient care. Regular auditing of the respective care bundle actions is designed to review and make improvement in patient care. We followed this up with staff and were informed that in regards to paediatric services HII were not used and care was evidence based. We were provided with evidence that urinary catheter care was managed in accordance with a set protocol.

For children who had undergone a surgical procedure we saw that there was information recorded of discussion around risks and consent forms had been signed by a parent. Checks in accordance with the World Health Organisation (WHO) safety practices were in evidence for each part of the child's journey between ward and the theatre environment. We saw in use an early warning alert monitoring tool, which enabled nursing staff to monitor and react to changes in an infants or child's condition.

We noted that the staff on the children's ward undertook monitoring of aspects of patient safety. This included hydration and nutrition, as well as pain assessment. Both the recent outcomes of the monitoring of these scored 94% and 96% respectively and were on display on the quality and safety noticeboard.

We noted that there were various safety practices in place, which included secure access to the neonatal and children's areas. Name bands were attached to each child, with red bands for those who had an allergy that staff needed to be aware of. Although we did not see any children without name bands during our visit feedback from a parent at a listening event indicated that their child was admitted to the ward without a name band. Name bands are required for identification purposes, as well as for safety checks for such practices as medicines administration.

Anticipation and planning

Nurse managers were responsible for ensuring that needs analysis and risk assessments were in place to determine

sufficient staffing levels, so that they were able to respond to changing ward/ department circumstances to cover sickness, emergencies and vacancies. We were able to discuss with the matron the staffing arrangements and how the ratio was set at 1:5, with seven nurses per shift both day and night. One staff member acted as supervisor. We were told that staffing could be increased if a child was in the high dependency area. We reviewed duty rotas for a number of past weeks and up to the end of February 2014 and saw that the staffing arrangements reflected what we had been told.

On an average day the number of children going through the assessment unit was said by staff to be between 20 and 30. Staffing arrangements were planned around the expected levels of service, such as elective surgical lists and outpatient clinics. Consultant and medical cover was arranged to ensure that there was always access to expertise, be that face to face or on the telephone. There were escalation processes in place for staff to follow if activity levels or children's care needs changed. Senior staff were available to monitor and respond to the changing needs of the service.

Staffing and skill mix

The trust had 10 consultant paediatricians with specialist knowledge in Oncology, Neonatology, Endocrinology, Epilepsy, Cardiology and Respiratory, and general paediatric medicine. There were 10 SpR, associate specialist doctor and 16 trainees. There was no separate neonatal/paediatric rota and weekend cover was said to be shared with Neonatologist. Copies of the duty rotas were provided for doctors covering the period 23 September 2013 up to 31 March 2014. We saw that the respective shifts were covered, with access and support from consultants; including on call arrangements and cover for the telephone help line. This meant that people using the service could be confident they would always be able to access the expertise of consultants.

The children's ward accepted admissions of babies from the age of 10 days old and teenagers up to the age of 16. However, teenagers aged between 16 and 18 who had long standing care within the service could request to continue their care on the children's ward. Staff said that babies accepted onto the ward may need care for problems such as jaundice or breathing problems. Elective and emergency surgical admissions contributed to the activity levels.

We discussed with senior nursing staff the staffing arrangements on the children's ward and were informed that recruitment was very difficult with a vacancy level for grade six staff nurses at 9.35 whole time equivalent (WTE) and no applicants to these positions. There were said to be between six and seven WTE band five staff nurses vacant also. The trust had held lots of recruitment drives and was trying to 'grow their own' but this would take time. Staff told us of the measures they were taking to address the shortcomings, such as going to job fairs as far afield as Glasgow and fliers in newspapers in the Glasgow area.

The nurse staffing levels required for neonatal services are clearly defined in the Neonatal toolkit published by the Department of Health (England) in 2009. The staffing levels are associated with the level of care provision in respect to special care, high dependency, or intensive are. We saw from the duty rotas supplied to us that there were sufficient staff to meet the varying levels of needs in the respective parts if the neonatal unit.

We received information that there had been plans before Christmas 2013 to cut staffing levels on the Neonatal unit. Plans were to drop staffing numbers to five nurses (including the nurse in charge) to cover a total of 28 cot spaces including a potential of four ITU and four HDU cots. The concern raised by the person was that five nurses to 28 special care cots would not even achieve the minimum standards. Another concern brought to our attention was that the practice development nurse was also due to leave the Neonatal Unit and no plans were in place to advertise this vacancy. At the time of the inspection we did not have any information to suggest that these cuts would still go ahead.

The duty rotas for nursing staff on the neonatal unit were provided to us covering the periods between December 2013 and 22nd February 2014. We saw that arrangements were in place to cover any gaps with regular bank (temporary) staff. We saw from duty rotas related to the children's ward that where permanent staff were not available arrangements were in place to cover shifts with regular temporary staff or agency nurses.

Although a member of the ward nursing staff did comment to us that at times it was "not so good" on the ward and this depended on staffing levels. They added that they would be happy for a child of theirs to be cared for on the ward. We found on the day of our inspection there were sufficient staff available to meet the needs of children.

Good

Services for children & young people

We were told by senior staff that there had been a review of the staff establishment to ensure patients were safe. Staff shortages were said to impact in the main at night and as a result bed availability was reduced by six during night time hours. We were told that no child had been turned away as a result of this reduction.

Staff were trained in a paediatric care and related disciplines so that they had the skills to understand and manage any risks related to their needs. The number of nursing staff who had obtained a recognised qualification in Neonatal care was seen to be 30. A number of staff were part way through this course and two were due to start the training in February this year.

We were told by a member of senior staff that they had completed an intensive care course and other nursing staff had completed the high dependency unit training. We asked about training in regard to advanced and basic life support. A rolling programme of advanced paediatric life support (APLS) was provided to staff but the matron who spoke with us could not say if there was always a member of staff on each shift who had this completed this training. Core standards that apply to services providing care of children and young people are that there is a nurse trained in APLS or emergency paediatric life support (EPLS) on each shift. Consultants we met told us that there were three consultants who were APLS instructors and there were three who were neonatal life support instructors. We were also told that all registrars had undertaken APLS.

Safeguarding

The trust provided guidance to staff in the form of a safeguarding children's policy. The content of this was reviewed by us and confirmed arrangements between the multi-agencies for the local authority of Berkshire. The policy also outlined the staged training arrangements based on level of contact with children for both clinical and non-clinical staff and the frequency of this.

We discussed with staff the arrangements that the service had in place to safeguard vulnerable children. Staff described how an alert system was used to inform staff of 'at risk' children and how this was updated regularly. Consultants said that this was working well. We were informed by staff that there was access to a nominated lead staff member who had responsibility for safeguarding matters. Staff also had direct access either by telephone or in person to either of the two dedicated paediatric Social Worker staff, who had an office on-site within the children's department. We saw that there was access to a Health Visitor also, should staff need their involvement. In addition staff had access to a paediatric doctor who provided two days of their time to child protection on a weekly basis.

Staff told us they had access to safeguarding training within the trust and we were provided with evidence of this training attendance. We saw that almost all staff had received level three training within the three year expected cycle of initial training and refresher update. Some training sessions were planned and booked for the coming months. Discussion with staff working in areas where children and infants received care provided us with confirmation of their knowledge and understanding in regard to identifying potential or actual safeguarding matters and how they would responds to these. For example, a staff nurse advised that they would inform the doctor and nurse in charge, as well as complete a safeguarding alert form. A play specialist was able to describe signs and symptoms they would be concerned about and how they would report such matters.

Staff on the neonatal ward explained how they had information provided to them where there may be potential safeguarding concerns prior to the delivery and transfer of new babies. They described how this enabled them to work with the new mother and other external agencies to ensure the safety and wellbeing of the infant.

Are children's care services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

Staff told us and we saw that they had access to a range of policies and procedures on the hospital intranet. Policies were written with reference to relevant evidence based guidance and the National Institute for clinical excellence. We looked at some examples of the policies available to guide staff and found up to date policies on 'Safeguarding' and, 'Modification of the Paediatric Surgical Pathway'. However, some policies had not been updated, including the policy titled, 'Consent in Paediatric and Neonatal Care', which was due to be updated in December 2013.

We saw also that staff had access to guidance on Epilepsy, Anaphylaxis (allergic reaction), Obesity and head injury. This guidance was based on the National Institute for Health and Care Excellence (NICE)

Consultants told us they met regularly to discuss research and current best practice. They also had regular time set aside for training, as did the junior medical staff, in order to keep their skills up dated.

Performance, monitoring and improvement of outcomes

There was an effective triage system in place within the A&E department, which enabled the needs of children to be prioritised. Children were either transferred to the assessment area of the children's department or directly onto the ward. Depending on the child's clinical state, if a Paediatrician was required in A/E as part of the initial assessment then they would attend.

The children's assessment unit was staffed between the hours of 7.15am through to 1.15am, which meant that children had access to an assessment or advice both as a new or a returning patient.

The Consultant Paediatricians also undertook monitoring of various aspects of quality outcomes that impacted on children. For example, we reviewed information provided to us in respect to the College of Emergency Medicines (CEM) audits indicated that the Pain in Children audit outcomes for 2012-2013 was that they performed very well in relation to other trusts. Similarly the Feverish Children audit for 2012-2013 found that the trust performed well in relation to the standards and other trusts, apart from recording and measuring systolic blood pressure, which they performed very poorly in.

Staff, equipment and facilities

The environment, provision of equipment and arrangements in place for staff ensured that children using the service received effective treatment and care.

Multidisciplinary working and support

We saw that the respective doctors worked collaboratively in managing the treatment and care needs of children and infants. Doctor's rounds were seen to be conducted in a purposeful way, with involvement of each doctor and nurse where required. Information was discussed in a discreet manner, preventing the disclosure of confidential information.

The multi-disciplinary team (MDT) included play specialist staff, teachers, as well as other medical related services. This included involvement of physiotherapists, speech and language and social workers for example. Records were made in patient notes where other members of the MDT were involved. For example, play activities were recorded by the play specialist.

A support worker who spoke with us in the neonatal unit explained how their role was to look after the babies and how they supported mothers by teaching and supporting them with such areas as breast and bottle feeding, general parent craft and preparation for going home. This staff member commented on the positive team working and how helpful everyone was to one another. They added, "we are treated with equal respect and value." Information to assist in ensuring that care was effective was said by this staff member to be communicated at handover between the shifts, both in the office and at "the cot side."

Senior medical staff said that they had good links with the haematology service, orthopaedics, and obstetrics. They added that the Radiologist would come to do scans if requested. The only problem on occasions was accessing X-rays out of hours, as there was only one person on site to respond to requests for major and trauma matters. The radiographer covered A&E and theatres as her priority, so calling in the second on call resulted in delays.

There were formal arrangements in place to handover between changes in consultant shifts in the morning, at five pm and again at nine pm. This meant that the incoming consultant was aware of any issues, safety concerns, or children who were unwell.

Multi-disciplinary meetings held within the neonatal unit, demonstrated to us that a range of issues were discussed by the team in order to improve working practices. For example, in the minutes of the meeting held on 5th January 2014, we saw that discussion had taken place about the provision of new breast feeding chairs and issues about breathing tubes having not been secured.

Good

Services for children & young people

Are children's care services caring?

Good

Compassion, dignity and empathy

During our visit we spoke with five children and nine parents. The parent of a teenager said in response to our questions about staff affording them dignity and respect; "Everything was explained" and added that staff were respectful towards both themselves and their child. Another parent told us that the staff in A&E were "fantastic", adding, "the girls were lovely and we were seen straight away." This parent said "the staff are good, keep us informed about what is happening and they are very pleasant." Our question about dignity and respect was responded to as "Definitely treated with dignity and respect." A child told us "Doctors are nice." The parent of an infant in the neonatal unit said to us, "Staff always treat us with respect; they are doing a great job." This parent had previous experience of using the neonatal unit with another child and said on all occasions "they had been looked after very well."

We received other positive comments from teenagers and their parents, including; "When I asked questions I had answers that made sense" and "Doctors explained in a way I could understand." Although a patient and their parent were frustrated about getting a diagnosis and moving forward they both said that the care had been lovely from staff and that staff "treated us respectfully."

We asked the family and friendly question to two teenagers and their parent and had positive responses in terms of recommending the hospital. One response was, "better than expected, level of care is very good and the nurses are cheerful and optimistic." The mother of a teenager said they had felt "looked after too." Another teenager said, "the care has been amazing." This person's parent was impressed with the pain management and that staff were "cautious in making decisions."

During our observations we saw staff interacting with children in an age appropriate manner and communicating with parents in a caring and compassionate way. Information was given in response to questions and staff took time to engage with both children and adults during the course of their duties.

A member of staff commented to us that as a department they were able to respect children and their parents as individuals. This person said, "I try to establish their needs and look at them from their perspective, looking for ways I can help." Another staff member explained how they tried to involve parents by inviting them to come to the neonatal unit before their babies feed so that they could have "a chance to cuddle them, change the nappy, and get used to them." They said how important it was to ensure privacy at times of breast feeding and that a screen would be provided to ensure this.

Involvement in care and decision making

We reviewed one care records for an infant on the neonatal unit and four from the children's ward in order to assess if care was planned and provided in a manner that indicated the involvement of parents or advocates. We saw that information was recorded by clinical staff that indicated an initial assessment of immediate and on-going care and treatment needs. Information was personalised as far as possible in respect to age and included where relevant information about the child's preferences.

Parents who spoke with us said they had been involved in discussions about the needs of their child. Whilst some parents we spoke with did not recall the care plan as such, they did say they had been suitably informed about investigations and updated with regard to their child's progress. One parent in the neonatal unit said they were told "what we can expect to see in our babies progress. " They also said, "The staff are caring and skilled. " Another parent said the nurse involved them in "the assessment of needs, such as eating and sleeping."

A parent on the children's ward said that staff were very helpful and that they had used the hospital a few times and found staff to be friendly. They told us "The doctor explains tests and keeps me informed. I am able to stay and appreciate this."

The named nurses responsible for each child's care had been recorded on the care records on the children's ward.

Consent was obtained with reference to the guidance; Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2013).This provided guidance to staff on the ways of seeking consent from children and young people. Consent was obtained prior to such treatment as surgical procedures usually from their

parents, legal guardian, or representative. Where this was not possible, staff made decisions about children's care and treatment in their best interest. This process would involve the individual concerned and other relevant healthcare professionals. Staff had access to training in respect to the Mental Capacity act (2005). In respect to informed consent the teenager who was due to go to theatre and their parent said they had been fully involved and the patient had been able to sign the consent form. This demonstrated to us that staff respected the patient and recognised the principles of informed consent.

Trust and communication

A parent whose infant was on the neonatal unit said they could tell someone if they had any concerns but there had never been any issues. They added, I know what is going on and I am very grateful."

A member of staff said to us that "Information provision is part of my role and I have used the translation service" in order to assist in providing information. This staff member showed us information that was used to communicate to children in a meaningful way the experience of going to theatre. This was in a pictorial format. We also saw information leaflets on subjects such as Hydrocele written in alternative languages for those who did not speak English as a first language. Leaflets on bottle feeding were available on the Neonatal unit in Urdu and Polish. Another member of staff explained how they had arranged a Polish translator on one occasion.

We spoke to a parent of a young child and they said that they had been given information by the doctor. They stated they were very happy and would fill in a complaint card if they had any matters to raise.

The ward environment provided visual displays to parents and visitors, as well as children on a range of matters, such as allergies, sleeping, and diet. We noted that some of the information was written in other languages, which meant that staff took into account the varying cultural and language needs of people using the service. We saw information to people about the national neonatal audit programme, including how such information collected by the hospital was used, and information about accessing the counselling services.

Emotional support

We were told by a parent that they had been given information to support them in the form of access to help and advice, whatever time. They found this reassuring.

People have access to parent support groups for Diabetes, Oncology, and Cystic Fibrosis. There are also coffee mornings following discharge home for parents whose babies were born prematurely.

Are children's care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The educational needs of children were met through the provision of teaching by two teachers. They were said to be employed by the local council. Schooling was not provided at weekends or during holidays. The school room was well equipped and children had access to a garden.

Consultants explained to us how the junior doctors undertook competency based training in order to meet the changing needs of children. This would include recognising the unwell child and medicines. They were said to be required to complete homework on prescribing medicines and intravenous fluids, with submission of work which was marked.

Arranging additional services to meet the needs of children was said to be difficult by consultants. They cited an example where they had requested services of a dietician but that this took eight months to sort out. We were told that procurement made decisions at times without any discussion and it was not always possible to understand where the blockages were. Such delays had an impact on meeting people's needs in a timely manner.

One teenager reported that they had mixed messages about what they could and couldn't eat which had added to the level of frustration. When we asked about food provision we were told that plain food was in the main sandwiches and that the parent had to bring jelly in.

We were informed that there was one qualified play specialist, supported by two other staff. This enabled the provision of play activities both in the play area and at the

bedside. One child who spoke with us said, they liked going to the play room and also could have play activities whilst in bed. Nursery nurses were also part of the work force, providing direct support to patients, their families, and staff.

Vulnerable patients and capacity

Staff had received mandatory training in basic conflict resolution and equality and diversity awareness. Staff understood people's cultural needs and said they could access interpreters through language line or using staff. A range of information leaflets and visual displays on the ward were written in alternative languages.

The children's service had systems in place to meet people's religious and cultural needs, although in some respects this was limited. Whilst staff said they could arrange meals to cater for the varied cultural differences parents of children said that they were not made aware of this. We saw that a daily menu was displayed on the children's ward but this did not mention that where alternative foods were preferred, these could be ordered. One child who spoke with us said they liked the "pizza and chips"; however, the parent of this child said that they had to bring in Asian food to meet the preferences of their other child, who was also a patient.

Access to services

The children's services included a children's clinic, which was found during our observations and in discussion with staff to be a self-sufficient and well organised arrangement. Although additional expansion would enable the service to encompass other clinics held elsewhere in the hospital, such as ear, nose and throat (ENT) and general surgery. The service had their own booking system and staff was able to collect relevant notes directly for the joint clinics, which were held with visiting consultants. We found that secretarial services for this department were well organised and they ran their own system which meant that information was turned around very quickly, such as patient letters.

A separate walk in nurse led blood clinic operated from the children's assessment unit between the hours of 8am and 9.15am. Results were provided directly to the child's general practitioner (GP). A doctor did comment to us that the blood processing by the pathology was slow at times, which caused delays.

The assessment unit provided 24 hour access to any child who has been previously discharged and accepted GP referrals via the registrar on call. A triage process took place on arrival of the child, which included an assessment of their vital signs and blood tests. Discussion with a parent whose child was waiting to be seen in the assessment unit told us that they had come through A&E and that there was a wait to be seen in that department by a doctor. They had been in the paediatric section of the department but apart from this delay they had no complaints.

A parent whose child had gone through the paediatric assessment unit explained how they felt things "needed to speed up there." They said, "It wasn't busy but we waited a while because of a bed block on the ward." They did say that their child was seen by the doctor on the assessment unit. Their child had also gone through A&E and it was said to us that the speed of being seen was very good.

Leaving hospital

Discharge planning information was present where relevant in care records we reviewed and information to be shared with the child's general practitioner was available. This indicated that information in respect to the child and on-going care needs were shared with necessary external agencies. A parent of an infant in the neonatal unit explained how they had a rough idea about the discharge of their baby but the priority was "getting them better and all was going to plan." A parent on the children's ward said they were waiting to see the doctor about their child's discharge.

Consultants informed us that the discharge process from the ward was managed safely in that all children had to be reviewed and discharged by a senior doctor. Junior staff were not permitted to discharge children.

Where babies were discharged from the Neonatal unit under 28 days of age, staff were required to send a 'BadgerNet' discharge letter to the community midwives so they could ensure the baby and mother were followed up.

Learning from experiences, concerns and complaints

Children who used the ward area were encouraged to feedback any issues that they felt needed to be addressed. For example, we saw a 'wishing tree' displayed on the wall. Children and adults had attached leaf shaped comment papers with ideas and suggestions. This included: More artistic staff in the playroom, Wi-Fi and more assistance for

loan carers. Where these had been addressed by the ward staff, a response was provided. In addition we saw that patients could comment about their experience, such as their experience being made ideal by having 'smiling, kind doctors and nurse' and 'not to talk over me', as well as 'being listened to'.

We reviewed the complaints data for the trust and no complaints were identified in respect to children's services since September 2013, when five formal complaints were made. Prior to that there were three formal complaints made in August 2013. We saw that each complaint had been reviewed and that where lessons learned were identified, these were addressed, for example, improved communications and improved inter hospital transfer arrangements.

Departmental layout

The children's and Neonatal ward areas were contained within a designated part of the hospital, and included such departments as children's clinics, an assessment unit, well equipped school room and a large play room for young children. Separate areas for teenagers to access games consoles, computer and music were available. The Neonatal unit was within close range of the children's ward and was found to be designed with separate areas according to the needs of the infants, including high dependency care, isolation rooms and nursery cots. Overall, we found that the neonatal unit was cramped, particularly in the area where high dependency care was provided. In all ward areas we saw separate room provision for managing waste, storing and preparing medicines and treatment available to staff. On the Neonatal unit there were a number of rooms available for mothers to stay overnight, with access to showers and toilets.

On the 29 bedded children's ward we saw bay areas, which were relatively cramped with six beds separated by curtains. A number of single rooms were provided, some of which were being used for isolation of patients at the time of our visit, with appropriate signage in place to indicate this. In addition to this, one room was designated for high dependency care, which we noted was equipped with necessary items to support a child or young person if needed.

We saw that staff tried to accommodate teenagers in the bay areas without the presence of younger children; however, we noted that in at least one side room, a teenager was sharing a room with a much younger child, who was in a cot. In discussion with the teenager and their parent about the room arrangement they did not express a concern about this; however, they did express a concern about the teenage toilet facilities. We looked at these facilities and found them to be unsuitable for teenage use as the toilet was low level, designed for young children. We asked a matron about the accommodation for teenagers and were told that "clinical needs sometimes take over the ability to put people in the right place." This factor had been considered when a teenager who initially was in isolation was then re-allocated to a six bed area, even though much younger children were present. The allocation to this area meant that they could be observed more closely. The teenager in question who spoke with us did not feel that this was a real problem, though they said it had been noisy the previous night but understood why they were in the bay area.

Within the A&E department there was a designated paediatric area, which we found to be child friendly and equipped to meet their needs accordingly. This area was found to be an ideal environment and was seen as an exemplar for others. The paediatric resuscitation area was less child-friendly; lacking any children orientated pictures or distractive objects.

Are children's care services well-led?

Good

Vision, strategy and risks

We asked the consultants if there was a hospital wide strategy to deliver quality care. The response was that as an isolated unit they had their own standards but that they amended what was out on the general wards for paediatrics." They responded with a "yes" to our question does the trust have a vision? In contrast, there were varying responses to our questions about the hospitals vision to less senior staff, for example one staff member said; "Every hospital has a vision", adding, "I don't know about the hospital but for children, yes, to deliver high quality care." A nursery nurse had some awareness of the hospitals visions and could recall some of the quality elements of this.

The consultant team expressed a positive reaction to becoming part of a new division for women and children. They saw this as an opportunity to represent the service upwards to the Board.

Good

Services for children & young people

Governance arrangements

There were effective governance systems in place related to children's services. Risks were identified and escalated to the division and trust Board level through a range of committees. We were informed that paediatrics and neonates health care governance meetings were held monthly with regular agenda items including A&E, pharmacy and safeguarding. A summary of incidents involving children and neonates were presented at these meetings by the respective leads after they had been investigated. Learning points were said then to be discussed and individual feedback given to the reporter. Weekly briefings took place with medical and nursing teams as part of the handover process.

Clinical governance meetings were taking place in the children's clinic and the sister advised us that she attended these meetings. A private paediatric board meeting took place on a monthly basis where governance issues were discussed along with other matters such as coding of incidents. Quality reports were made available to divisional leads.

Leadership and culture

Staff had clearly defined roles, including those who had responsibilities as leaders. There was a lead Consultant to oversee clinical staff. A lead nurse had responsibility as a trained paediatric nurse for the nursing services.

Senior medical staff commented on the positive nature of the department, the effective working relationship and overall cohesiveness. They said that any problems were resolved between the team and overall they worked together in a positive way. One comment made by a consultant was, "I am completely convinced I could not work in a better paediatric department." When new staff came to the department they were seen to settle quickly and generally had a positive experience. This was echoed within nursing, with student nurses enjoying their apprenticeship. A comment made by nurse representative was that some staff go to new post after qualifying but return within six months.

Consultants expressed general feedback in regard to the constant change at executive level and how continuing changes meant that stability was harder to achieve. That said they did not recognise some of the issues affecting other parts of the trust because of the isolated nature of the service. They did not get involved with other areas, with the exception of paediatric A&E but said they took the matters seriously.

They did say that there wasn't a voice for children on the trust board. We were also told that they had good links with the executive team and that they would "not hesitate to pick up the phone" to discuss matters.

A matron expressed the good relationship with doctors and said that they were able to call the consultant out of hours for advice. They also said there was a good relationship with the lead nurse.

Staff working in the children's ward areas informed us that the chief executive was visible and provided information on a regular basis which they found useful. This included emails, a team brief in addition to 'fliers' from their own department. We were told that matrons were visible and approachable, and that there were no difficulties in raising an issue.

One member of staff said, "I wouldn't be here now if it wasn't a good place to work." They added, "There has been lots of support for me and to lead the area." We reviewed information about the level of staff performance development reviews (annual appraisals). Figures provided indicated that there was a compliance rate of 94.5%. Reasons for a performance review not having taken place included the staff member being on maternity or long-term sick leave. A play specialist said they had received an annual appraisal and they had been supported to access external courses to assist in their development.

One of the doctors told us it was "a good experience" working in the children's service. They said there was always good support from the senior registrar and consultants and they were always available. The only negative thing for them was the shift pattern, which was said to be inflexible. They sometimes found it difficult to get to the teaching sessions on a Tuesday but when they did, the sessions were said to have "good educational value." This same doctor said that the induction process was good, with one and a half days, plus some preparation beforehand.

Medical and clinical staff expressed concern about the response and actions of the human resource department.

Good

Services for children & young people

One comment made in relation to recruitment was that "HR processes are tortuous." Staff told us of inaccuracies in adverts and delays in advertising. Staff said they didn't always get informed when an advert had gone out.

Patient experiences, staff involvement and engagement

A play specialist said that where an investigation was required as part of incident reviewing they would be involved in this if necessary. They also said that they felt like they were treated with equality and fairness and "very much felt included." Staff told us that they had a good working relationship with doctors and one said the "doctors are approachable." Staff said they had good support and there was "always someone to talk to."

The paediatric assessment unit was seen to be well run and staff who spoke with us said they felt "well supported" in their roles. We were told by a staff member that they had supervision and an annual appraisal. They said that as a part time worker they were also required to attend mandatory training, which they confirmed included infection control management of blood transfusions, safeguarding, and resuscitation. Staff had a positive working relationship with children and parents who used the services. A parent who was waiting in the assessment unit told us that they would recommend the hospital to friends and family. Another parent who we spoke with on the telephone following receipt of some information from them said that as parents they felt that the experience of their child was not a positive one as a result of problems in the post-operative recovery period. Other comments from people about the experiences of their children and themselves as parents were generally positive.

Learning, improvement, innovation and sustainability

Staff monitored various areas of practice through audit, such as infection control, medicines management, and record keeping. Where actions were required to improve areas, these were addressed. Staff who were developing their skills and experiences followed a formal enhancement of practice and learning programme. Other staff followed a continuous professional development plan. Training in simulation exercises for the multi-disciplinary team took place on ward areas and in a designated training area known as WexSim.

Requires improvement

End of life care

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

Information about the service

The Palliative Care Team at Wexham Park Hospital are part of the integrated Specialist Palliative Care Team across Berkshire (including hospice and community). The hospital team consists of a Consultant in Palliative Medicine, Macmillan Consultant Nurse Practitioner Palliative Care, 1.0 WTE A&E/ AMU Advanced Nurse Practitioner (ANP), 2.8 WTE band 7 ANPs, 0.8 WTE end of life practice educator, and 0.6 WTE of a band 6 ANP. The team also has specialist occupational and pharmacist support.

In addition, a chaplaincy team provided multi-faith support. The Eden Unit has piloted a dedicated pastoral care worker and the pilot has led to successful funding for an 18 month project of three 0.5 WTE pastoral care workers who will support patients from ward to home/ hospice. There was no dedicated bereavement team, relatives of the deceased were provided with support by the Patient Affairs Team.

The palliative care team are available Monday- Sunday, 8.30am – 4.30pm for direct face to face assessment and care of patients and families. 24 hour consultant palliative medicine advice is available via the hospital switchboard.

During our inspection we visited the oncology ward (Eden ward) as well as other wards to assess how end of life care was delivered. We also visited the mortuary and spoke with palliative care leads, ward staff, patients, and relatives. We looked at patients' notes and reviewed documents relating to the end of life service provided at the trust.

Summary of findings

Patients received safe and effective end of life care at Wexham Park Hospital. Patients care needs were being met and the service had established good working relationships with community services.

Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect by all staff they encountered. Staff supported patients to be fully involved in their care and decisions. The end of life team was well-led at a local level, and staff were dedicated to improving standards of end of life care across the hospital as a core service, rather than a 'specialty service'. There was a programme to disseminate learning and training throughout the trust. The drive and vision was that of the palliative care leads and not through any trust wide strategy however, and we were unable to find consistent evidence that end of life care was a priority for the trust board and staff were not aware of an executive director taking leadership in EOLC.

Requires improvement

End of life care

Are end of life care services safe?

Requires improvement

Safety and performance

There was an end of life multi-disciplinary governance group who monitored performance and identified area of concern. The terms of reference for Trust Clinical Governance Committee for the end of life governance group stated that an annual report would submitted to the Trust Clinical Governance Committee and be chaired by the trust deputy medical director. However the minutes showed that neither of these had occurred during the last year. The end of life governance minutes gave a clear account of the any issues and how they would be responded to prevent any reoccurrences. There was no previous evidence of unsafe care or safeguarding events.

Learning and improvement

On Eden ward we saw the staff communication book provided staff with information about learning and development from incidents relating to communication. The end of life governance group monitored performance and any recommended training needed in response to these. The group also evaluated the care of dying patient and had introduced training in response to this.

Systems, processes and practices

The provision of equipment, such as syringe drivers, were available from the equipment library but staff on Eden ward informed us that there had been a shortage of 10ml syringe drivers and therefore had been using 50ml drivers. Staff told us this was problematic because they were using 50 ml syringe drivers with different size syringes and taping them into place. The staff confirmed that had ensured the flow rate and calculations for the administration of the medication was correct but expressed their view that it was difficult to manage with an oversized driver. There was a possible risk to the patient of the incorrect dose and/or flow rate for the administration of the medication due to the use of an incorrect size syringe. Later in the day we were informed that an order for new syringe drivers had been placed.

Are end of life care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

Following a national report into its usage the previous used guidance for end of life care (the Liverpool Care Pathway) is being withdrawn. In response to this the palliative care team have developed an Integrated Care of the Dying Care Plan (ICP) following guidance and recommendations from Leadership Alliance for the Care of Dying People. This plan was used to plan and document the care of the dying patient and their families. This care plan was only used when the multi-disciplinary team (led by the Consultant) agreed that a patient's death was inevitable, unavoidable, and imminent. The approach to care was focused on comfort and dignity. It planned all aspects of care with the full involvement of the patient (if possible) and their family / loved ones.

The governance group undertook a wide range of activities to develop and assess the quality of the end of life care being provided. Minutes of the meeting showed that audits looked at areas such as the completion and use of DNACPR, also the progress being made on pilots such as the AMBER care bundle, delivery of trust wide training, the matching of the ICP to national guidance and ensuring the trust website was updated with the new information. Throughout the minutes it was clear to see that the patients and relatives experience and involvement was considered within the discussions. The minutes included little in the way of actual figures/data as these were presented separately.

The quality audit dashboard for Eden ward was started in August 2013 and included areas such as documentation, pain, nutrition, and hydration. Those audits completed showed between 90-100% achievements.

Staff, equipment and facilities

The palliative care team identified training required trust wide to provide all levels of staff with the necessary skills and knowledge to care for the dying patient. This included doctors, (F1 &F2 doctors) who received training during their induction. Training was developed and shared with the local hospice and used these resources for clinical supervision. Funding had been agreed to employ a

dedicated end of life educator/practitioner. On the oncology ward (Eden) the nursing establishment had recently been increased and these new posts were being recruited to.

In addition, on the Eden ward external funding had been secured for the all cancer specialist nurses to be trained in advanced communications and level II psychology, this should enable them to support patient with expressing and understanding their feelings. There was also work with the hospice to sustain clinical supervision monthly.

Multidisciplinary working and support

This was a multi-disciplinary team led by the Palliative Medicine consultant and Macmillan Consultant Nurse Practitioner, Palliative Care. Some of these included were the palliative care pharmacist, end of life practitioner for AMU & A&E, patient affairs, anatomical pathology, a dedicated educator and a small team of nurses. There were strong working relationships with the oncology team and ward. The chaplaincy team were also an integral part of the emotional and spiritual support provided to patients and loved ones.

The palliative care team had established an effective working relationship with the local hospice. The palliative care consultant had admitting rights to the hospice as well as at the hospital. There was joint working with the hospice and innovative work was underway to share experiences working in each other's service. The team worked with services in the local community to support people to have their wishes and preferred place to die achieved. There were also strong working links established with Macmillan Cancer Support.

The multi-disciplinary working was further evidenced in the recordings in the ICP with good results and patient experience.

The handover in relation to the patient care was via the Integrated Care of the Dying Care Plan (ICP). The patient continued to receive care and treatment from the medical team for any existing medial needs, with the end of life programme of care provided by palliative care team. The ICP was used by all of the multi-disciplinary team to record their involvement, instructions, and delivery of care. Its effectiveness was constantly monitored and recorded, with any changes reported to the palliative care team. There were arrangements for multidisciplinary team working outside the trust through working relationships that had been established.

Are end of life care services caring?

Good

Compassion, dignity and empathy

All patients and relatives we spoke with who were on the ICP spoke very highly of the care received and how they had been treated with respect and dignity. On Eden ward relatives spoke highly of the compassion shown by all staff and were full of praise and appreciation for how they had been cared for and supported.

Governance minutes showed that complaints related to visiting times. On some wards staff had rigidly stuck to the visiting times despite the patient being cared for was known to be end of life. The trust website says the final decision regarding visiting times was with the ward matron. However when a person is at the end of their life with just days or hours to live, to not allow them to have as much time as possible with those closest to them shows a lack of empathy and compassion. The restriction of visiting does not respect patient and relatives wishes and civil liberties and could have a detrimental impact on people's well-being. On some patient notes we saw that it was documented that they were entitled to open visiting.

Involvement in care and decision making

Patients and relatives we spoke with described how they had been involved and kept informed of what was happening. The majority explained how they had been part of the decision making. On Eden ward a family shared with us their personal experience of having very open and honest discussions about what to expect and what the various options were. They felt they were provided with enough information and understanding of the options which helped them to be actively involved and that there was no pressure to make any particular choice. This was then supported by the ICP records, which confirmed the relatives and patient involvement.

Trust and communication

Relatives and patient said that the way things were explained to them, was clear and in simple language and

End of life care

not full of medical jargon. This helped them to feel confident about understanding what was being discussed and explained. One family said how they had confidence in those caring for their relative as everyone including the palliative care medical lead and the ward staff had allowed them time to talk, and ask questions. We observed care being delivered and how the nurse took the time to explain to those present what they were doing, reassuring them what was happening and why. This was a very emotional time but the staff on Eden ward demonstrated how they had built a good rapport and relationship with the family.

Emotional support

Patients and relatives felt their emotional needs were well supported. In Eden ward there was a room for discussions. In ITU there was a quiet room for interviews and a room where relatives of dying patients could stay the night. The unit had a specialist organ donation nurse who supported relatives in making decisions about organ donations, end of life care, and withdrawal of treatment.

The Patient Affairs Team offered guidance regarding the process after someone has died. They could arrange for people to see the doctor who was looking after the patient, so to help understand what happened. The booklet, 'Following the death of someone close' was seen to be available on Eden Ward and electronically on the website, along with other information about what to expect and do after someone has died.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

We found that both nursing staff and medical staff were aware of the ability to refer patients to the palliative care team. During a ward round a patient was identified as needing the input from the palliative care team and a referral was made. The team responded quickly to referrals seeing patients within 24 hours but often the same day.

Patient care was planned and individual, respecting the needs and wishes of the patient and the family. The palliative care team and the staff on Eden ward described how they care for the patient and the family Staff we spoke with were focused on treating patients as individuals and getting the best outcomes they could for each person. The patient records we looked at showed individualised care planning with targets and goals tailored to each patient's needs. The ICP clearly set out patients care needs and was used by all those involved in the delivery of the programme of care.

The introduction of the AMBER pilot meant that once patients were registered on this programme they were able to fast-track services as their condition had already been identified and a plan was in place. There had been occasions when access to oncology beds had been restricted by patients who were medical outliers were placed in the beds.

There had been the introduction of facilities that would help with patient's well-being. This included the provision of funded complimentary therapies such as reflexology and aromatherapy. This service was provided through the ward charity fund and was in its second year. The Macmillan living well programme was a holistic approach that delivered an 8 week programme of specific information to help support patients and carers. It also included an exercise programme, a support group, psychology level IV and the HOPE course.

The local community was multi-cultural; there was a chaplaincy service within the trust to meet people's spiritual needs. Within the chapel there were the facilities to accommodate a wide range of different faiths and beliefs. The chaplaincy team included different faiths; Hindu, Muslim, Sikh, Roman Catholic and Church of England. There was a book of remembrance for babies.

Governance minutes also recorded how there has been an ongoing issue of pressure being placed on ward staff to vacate a bed as soon as a patient had died. The minutes record that the ward should be able to keep the deceased patient for up to four hours to allow family to stay with the patient.

Vulnerable patients and capacity

We saw evidence of appropriate use of DNACPR for those who were on the ICP. We also noted that lasting power of attorneys were verified to ensure the person had the authority to make any decisions. Systems were in place to protect the patient's rights and wishes, such as best interest meetings.

Requires improvement

End of life care

The trust had recognised that, at times, there is insufficient clinical support for teams making these decisions regarding DNACPR. It also noted that communication of these decisions to patients was not sufficient. Of the DNACPR forms we viewed, a third did not record that there had been any involvement or discussion with the patient or relative regarding this decision. We checked the patient's records to see if this contained any record of a discussion for these patients but it did not. The annual audit undertaken by the resuscitation team into DNA CPR confirmed that there was a trust wide issue (with the exception of the intensive care unit) with recording discussions in notes. We were told that work was being undertaken to address this but there was no evidence from previous audits that this had improved year on year.

Access to services

The palliative care team accepted referrals from the patient, relatives, nursing, and medical staff. The trust website provided information on how to do this and the contact details. Referrals would be responded to within 24 hours. From patients notes we saw that the team frequently responded the same day as receiving the referral.

Referral to the palliative care team also then made services such as the local hospice and Macmillan services available to the patient and their family.

A common theme for complaints related to the car parking, both the cost and the lack of parking spaces. The trust had not made any concessions for visitors of patients who are end of life. Previously a parking permit would be issued to relatives of patients on Eden ward, but people abused the system and so the permits were discontinued.

The mortuary had been experiencing capacity issues for over five years. A temporary storage unit was housed in the high risk post-mortem room and Heatherwood Hospital also has a mortuary which can be utilised. We were informed the other rooms met the criteria for high risk cases, and the times of cases required careful planning. However the capacity situation had continued to be a problem. The trust risk register identified this and the installation of an additional freezer had been actioned. However several months after installation the freezer was not in full working order. The freezer would only resolve the need to provide additional frozen storage and not the short term fridge storage. The mortuary entrance and viewing room was not welcoming for relatives and was in need of refurbishment. The viewing room had no religious symbols present but the mortuary staff would support families with religious wishes within legal parameters. The department was clean, but there was an odour, which some relatives may have found distressing. There were no long term plans in the trust risk register for redeveloping the mortuary.

Leaving hospital

The palliative care team actively supported the patient and the family to achieve their final wish with their preferred place to die. This included when patients had complex care needs and wanted to die at home. The team would collaborate with their colleagues in the community to enable this to happen.

Are end of life care services well-led?

Good

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Requires improvement

Outpatients

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

Information about the service

The trust has six locations from where it provides outpatient services. Wexham Park Hospital is the main site and is based in Slough. Each year the trust has approximately 86,412 new outpatient appointments and 173,005 outpatient follow-up appointments. Services include ear, nose and throat (ENT), orthopaedics, paediatrics, oncology, cardiology and radiology.

King Edward VII Hospital is located in Windsor and runs a number of outpatient clinics each week. These include pain management, cardiology and lump in the neck clinics.

Summary of findings

We found that some improvements were required to keep outpatients services safe for people at Wexham Park 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 hospital outpatient services were not responsive and we have rated this area as 'inadequate'. 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. At a local level there was good leadership, but this needed to be improved at senior management level.

Requires improvement

Outpatients

Are outpatients services safe?

Requires improvement

Safety and performance

Our observations of the care provided to people showed very good interactions between staff and patients that enabled safe care to be provided. This included clear explanations about the illness/condition, how it would be managed, and how to take medication safely. 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.

Systems, processes and practices

We looked at the trust's systems for the prevention and control of infection at Wexham Park Hospital and King Edward VII. The trust's monthly hand hygiene audits showed that the outpatients department (OPD) in Wexham Park Hospital scored 100% compliance in October, November, and December 2013. The results of the corresponding audit at King Edward VII showed compliance scores of 90%, 95%, and 90% for the same months. However, this level of compliance was not reflected in our observations during our inspection.

At Wexham Park Hospital we observed various areas of the OPD to see whether staff and visitors used the hand sanitiser gels that were located throughout the units. We observed poor compliance with the use of hand gels. For example, we observed the main reception area for 10 minutes and in that time we saw no staff or visitors use the gel, nor was anyone directed to use it, despite trust staff and volunteers being present. This was also the case in the clinics we observed. At King Edward VII Hospital, we looked at the OPD area and the chest clinic. In neither of these areas were there any signage or hand gels available in reception or in the waiting areas to encourage staff, patients and visitors to use it. When we raised this with the matrons of the respective areas we were told that the trust's policy to use hand gels 'at the point of contact'; however, we spoke with two people that were leaving the hospital following their OPD appointments and they told us that they had not been asked to use the gel. This meant that there was an increased risk of cross infection.

At King Edward VII Hospital we saw that there were sinks in a number of clinical areas, the minor surgery area, and the utility areas that did not comply with current Department of Health guidance (HTM64). This meant that there was an increased risk of cross-infection. We also saw that the hospital still used fabric privacy curtains. We were told that they were changed every six months, or sooner if they were soiled, and that the trust was moving towards replacing these with disposable curtains. Regardless of which curtains were being used, there was not a system to ensure curtains were systematically replaced. In the minor surgery room we saw there was a fabric-covered chair. Surfaces in clinical areas should be non-permeable and, therefore, there was an increased risk of cross infection. This was particularly concerning given that this room was used for invasive treatments.

In one clinic at Wexham Park Hospital we saw staff about to take a drinks break in a clinical area. However, when they saw the inspector they moved to a dedicated breaks area.

Monitoring safety and responding to risk

We found from our interviews with staff and the divisional management teams that there was a clear understanding and awareness of the risks that affected the safe operation of the OP service. These risks were discussed in the divisional governance reports we saw for the quarters two and three of this year, 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. This showed that although there was much work still to do that the systems were being established to facilitate improvements and improved safety.

However, we found that there was no risk management policy available for staff reference, only a trust strategy. This meant that staff were not given the guidance they needed to implement effective risk management.

At the time of our visit the angiography suite was out of action as dirt had fallen out of a ceiling vent/ air-conditioning unit whilst an operating list was in underway. Fortunately, there were no patients undergoing a procedure at the time the dirt was discharged. However, this could have caused injury or infection had an operation been in progress. This also meant that the vents in that area had clearly not been maintained properly to ensure that the clinical area was safe to use. We were told that two

days' operating lists had had to be cancelled whilst the vents were fixed and the area fully cleaned. We were advised that the matter had been raised and escalated as a serious incident. Hand hygiene compliance in radiology was also poor, with only 85%, 90%, 80% scored for the months of September to November respectively.

We saw that in all areas we visited that resuscitation trolleys and emergency medicines had been checked daily and were properly stored to ensure they was ready to use in the event of an emergency.

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 they had received this training and discussed actions they would take to raise and escalate a matter if they suspected that abuse had taken place. Staff in the paediatric outpatients department were trained in safeguarding to level 3. This included the receptionist, who also had basic life support training. This was due to the fact that the receptionist was the only person that was permanently based in the waiting area and observed children waiting for their appointments. This was good practice.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Performance, monitoring and improvement of outcomes

Equipment was found to be well-maintained but front-line staff and divisional managers advised that the department had been under-resourced for a number of years had lacked leadership and had struggled to be effective. There had been a shortage of radiologists and there was currently only one sonographer in the trust that was able to carry out vascular scans. This area was the subject of monthly monitoring and action planning.

Elsewhere within OPD we found that clinical areas underwent a start-of-day check to ensure they were equipped with essential kit that was serviced and in a good state of repair.

Space within the OPD at Wexham Park Hospital was restricted and this had an effect on the amount of room available for people waiting to be seen. This was a particular problem in the phlebotomy clinic, where we found that patients had to stand in the corridor to await their appointment. This was uncomfortable for them and blocked the corridor, creating an environmental risk.

Multidisciplinary working and support

At King Edward VII Hospital some of the trust's cardiology clinics were being run by consultants from other specialist trusts, allowing patients access to tertiary centre advice closer to their home. In addition in paediatrics staff had access to specialist doctors from Upton Hospital, a part of the local community trust service, for advice and shared care.

Are outpatients services caring?

Good

Compassion, dignity and empathy

From our observations, we found that good care was taking place on a one-to-one basis and that people were treated with compassion, dignity and respect during their consultations. We observed a child's appointment with the orthodontist and saw that the communication with the parent and child were friendly and that information was provided at a good level for both to understand. We observed a uro-oncology clinic where a nurse specialist did a good job of explaining the prostate cancer care pathway. They listened to the patient, discussed findings, and broke the 'bad news' in a sensitive and compassionate way. We also observed good, friendly nurse/patient interactions in the waiting area. We spoke with the mother of an adult patient that had a learning disability, who told us that they came to the OPD regularly for blood tests and that staff were always very caring, considerate and put them at ease. We spoke with one patient in the cardiology clinic who described staff as 'efficient, caring, and kind'.

Involvement in care and decision making

At King Edward Hospital VII we spoke with the mother of a baby that had just had a consultation with a doctor. They said they had not got the outcome from the consultation that they had wished for but they said that the doctor had been very good at explaining why the particular course of

action was not advisable at this time, and explained options for the future. Our observations of consultations also showed us that people were involved in their care and enable to make informed choices.

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 way relevant to the patient and their needs.

Emotional support

We observed an oncology clinic where the clinician broke 'bad news' to the patient. This was handled well and the patient was given support and information to understand the diagnosis and treatment options. Information and contact details of support groups were available. However, we were told at King Edward VII Hospital that the set times of appointments made it very difficult for staff to break bad news and provide all the care and support that the patient required. We were told that whilst the doctors took all the time they required to meet the patient's needs, the consequence of this was that subsequent appointments ran late.

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, we had major concerns about the responsiveness of the trust to meet the needs of patients at this time.

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. This was the biggest cause of complaint to the trust in OPD. We saw this in a cardiology clinic session, which should have started at 9am, but by 9.10 the clinician had not arrived. By the time the doctor started the clinic there were five patients waiting to see them. To compound the matter, two patients were booked to see the doctor at 9.30am and two more patients at the 10.30 appointment slot. The practice of double-booking was down to the individual consultant, with some of the opinion that they would rather have a patient waiting a long time to see them on the day than for them to have to wait a few more weeks for an appointment. However, this was ongoing despite it not being condoned by the trust.

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 less than six weeks, which was a breach of the trust's access policy.

We found that this and the way the bookings system operated was having a detrimental effect on the trust's ability to respond to people's needs. One person said they had been waiting since 4 November for an appointment at the cardiology clinic and had only found out what was happening today. They had visited the hospital the previous week but the doctor was late and did not have time to examine them. They described the standard of communication for booking appointments as a 'nightmare'. Another patient of the cardio service was told they needed to be seen within two weeks, but they heard nothing from the trust for a month. They then phoned the trust and was given an appointment for the following day. Another person was told they required an appointment to see the oncologist 'within two weeks' but had to phone the trust after three weeks as they had not been contacted. When we spoke with them they said they still had not got an appointment and said that it might mean they had to reschedule an appointment in neurology. They said they felt that the delays were compromising their care and was leading to a delay in surgery.

Staff we spoke said that it was not uncommon to leave work at 7pm for a clinic that should have finished at 5pm.

We were concerned about the radiology department's ability to meet people's needs. It was agreed by staff and management that the service had been 'dysfunctional' and that its facilities were not fit for purpose. Money had not been spent on the service and there continued to be a shortage of staff, which was compromising people's care.

Requires improvement

Outpatients

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 sign-posted 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 they had received some LD training. The lead nurse was the lead for LD, but they too did not have a LD qualification. We were told that the trust was trying to recruit a suitably LD-qualified person. In the paediatric OPD staff worked closely with doctors from the local community trust and had access to LD-qualified clinicians. However, these were not always available at Wexham Park Hospital or any of the trust's other OPD sites.

When booking first appointments the booking office was made aware if a person required patient transport (PTS), or if they required an interpreter. These would then be arranged.

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, in the cases of short-notice cancellation of appointments, this meant that 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, arrangement of clinics 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 and the trust was not fully meeting the 18 week refer for treatment target (RTT).

Leaving hospital

People using the OPD services were not admitted to the hospital and, therefore, left following their OPD appointment. However, 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

In response to the complaints and appointments issues we saw that the trust was regularly monitoring these areas of risk at divisional governance and board levels. 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 there were 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.

We visited the Patient Advice and Liaison Service (PALS) and saw OPD complaints about two-hour waits for appointments; consultants arriving late for clinics, or not being available at all; cancelled clinics and car parking. Complaints data was collected and we saw this for January 2014. The PALS did not receive any collated data from the trust management about complaints. Leaflets were available and sign-posted people that required these in other languages. However, there were no 'easy read' formats, which made it difficult for people with a learning disability to provide feedback and engage with the trust. We saw one complaint about car parking where a mother with a baby could not find a parking space for 30 minutes. PALS officers said that in such an event if this involved a breast-feeding mother, then they would be given free parking. However, this did not address the problem of there being limited spaces available.

Are outpatients services well-led?

Requires improvement

Vision, strategy and risks

Staff we spoke with stated they were unsure whether the trust had a vision and strategy. Two members of the nursing staff we spoke with told us about the '6C's', an initiative to instil a culture of compassionate care; however, this is a NHS-wide programme and not something unique to this trust. 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 the minutes of a recent team meeting had recorded that such a discussion had taken

place. However, they told us that there had been no action taken, or feedback given, about this. In respect of strategy, we found that staff felt that the trust was focussed on the move to merge with another regional trust later in the year, and that this had caused them to lose some strategic focus and, to some extent, identity and pride in the trust they worked for at this time.

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. These being the OPD appointments system. All staff were knowledgeable about the areas for development. We found a clear reporting process for risk and that these were regularly reviewed at team, divisional and board levels. The risk register was also completed and reviewed.

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 they had not received any incident reporting training. However, one nurse told us that where they might record a matter on Datix, the trust's incident reporting system, they did not always get feedback as to 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 of 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 they felt supported by colleagues and managers with in their teams. There was generally a good opinion of managers at divisional level. Staff at King Edward VII Hospital said they felt isolated and that staff activity and support was centred at Wexham Park Hospital. The staff in OPD said they also felt isolated from other hospital departments because although they provided care for patients across various specialities, they were not part of each specialty's teams.

In respect of staff at board level, 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 the OPD in Wexham Park Hospital often, and based herself at satellite OPD sites regularly. We were told at King Edward VII Hospital that she announced in advance when she would be coming to ensure staff could speak with her. She had also adjusted the timing of a visit following a request from staff at a busy time, so that she could see as many staff as possible. However, we did not find any members of nursing staff that recalled meeting any other board director, including the director of nursing, who had been in post since June 2013. They said that the director of nursing's predecessor had also not made a point of visiting the OPD when they were in post.

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 OPD departments we visited. Feedback was generally positive about the care they had received, but clinic times and the availability of parking spaces were a theme of the negative returns.

Staff told us about the various methods of communication within the trust, such as team briefs, team meetings, and messages within the communications book at each shift handover. However, they said they were not made to feel involved by senior trust management. Good teamwork and involvement existed within local teams and was facilitated by their own matrons and care group managers. One member of staff said this was done in spite of the trust management rather than because of it. Apart from engagement with the chief executive no other senior board member made a point of engaging with front-line staff.

Learning, improvement, innovation and sustainability

Doctors, nurses in different clinics and divisional managers told us that there was high turnover of middle-management staff which created a number of problems in leadership, service improvement, and sustainability. This had affected the timeliness of communication and engagement with consultants. In radiology we found that the service manager did not attend directorate meetings, which limited the amount of

information being passed on to the team. We were also told by the divisional chair, the operations director, and the lead nurse for OPD that such was the capacity of middle management that it was difficult for them to affect change in respect of clinic times issues.

The trust was attempting to address various issues affecting OPD in terms of clinic waiting times, and proposed 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 need 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.

In respect of improvements, we saw some areas locally where this was taking place. For example, the fracture clinic had commenced a Saturday morning session and operated six-days a week. It was recognised that the new service manager in radiology was making much-needed improvements to the service. However, they were only on six-month contract, so it was difficult to have confidence that improvement would be sustained should the service manager leave at the end of the contract. At an OPD-wide level, it was also difficult to assess sustainability given the amount of work that was still required and the apparent focus of the trust's move to a merger and the uncertainty that this brings.