Care Quality Commission

Frimley Park Hospital NHS Foundation Trust

Frimley Park Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Outstanding ☆
Accident and emergency	Outstanding ☆
Medical care	Outstanding ☆
Surgery	Outstanding ☆
Critical care	Outstanding ☆
Maternity and family planning	Good ●
Services for children and young people	Good ●
End of life care	Outstanding ☆
Outpatients	Good ●

Summary of findings

Letter from the Chief Inspector of Hospitals

Frimley Park Hospital provides acute services to a population of 400,000 people across north-east Hampshire, west Surrey and east Berkshire. It serves a wider population for some specialist care including emergency vascular and heart attacks. In addition to the main site, it runs outpatient and diagnostic services from Aldershot, Farnham, Fleet and Bracknell.

Frimley Park Hospital has around 3,700 whole time equivalent members of staff and hosts a Ministry of Defence Hospital Unit with military medical, surgical and nursing workforce fully integrated into the NHS staff.

We carried out this follow-up inspection in addition to our comprehensive inspection in November 2013, as Frimley Park Hospital was inspected during a pilot period when shadow ratings were not published. In order to publish a rating, we needed to update our evidence and inspect all core services. Because we had inspected the trust so recently (in November 2013) we did not repeat some parts of our usual inspection process. This included the unannounced visit (which took place at night) and the public listening event. At the public listening event in November we heard directly from about 100 people about their experiences of care.

In addition, due to the proximity of the junior doctor changeover date (the significant majority of the junior doctors changed post a day before the inspection) we did not speak with many of them during this inspection. However the feedback from those spoken with during the November inspection was overwhelmingly positive, describing a high level of support from their consultants and registrars which they told us had had a resultant impact on their personal confidence levels and medical practice. They went on to describe why this led to medical staff frequently returning to Frimley Park at a later stage of their training or as consultants. Specific comments included one doctor stating that the level of support she had received in her day-to-day work was “outstanding”, and another that although the workload was sometimes very heavy, the senior staff “led by example” and were very approachable. These findings are corroborated by the fact that Frimley Park is rated top for training within the Kent, Surrey and Sussex deanery by foundation trainees.

Overall, this hospital was rated as outstanding. We rated it good for providing safe and effective care and outstanding for being caring, responsive to patients’ needs and being well-led.

We rated A&E, medicine, surgery, critical care and end of life care as outstanding. We rated children and young people’s services, maternity and outpatients as good.

Our key findings were as follows:

Safe:

- Frimley Park Hospital was one of the first 12 trusts nationally to sign up to the NHS England “Sign up for Safety” Campaign. A safety culture was a priority for staff at all levels and was embedded throughout the trust. Learning from events was encouraged and we were given multiple examples throughout the services of how care had been improved as a result of incident reports and investigations.
- Wards were well staffed from both a medical and nursing point of view. Where shortfalls had been identified, the senior team were aware and action plans were in place to address this. Where temporary staff were employed there was sufficient training to orientate them to the trust.
- The hospital was clean and staff were witnessed to follow good hygiene practices. Audits were undertaken routinely by the trust and action was taken if areas or staff groups were not compliant with expected cleanliness standards.

Summary of findings

Effective:

- Staff based care delivered on best practice guidelines. Local outcomes were regularly audited and the trust was able to demonstrate how it had changed practice to improve results for patient's year on year. The trust also benchmarked itself, and compared well against, national comparators.
- There was strong multidisciplinary team working throughout the trust. Staff worked alongside each other for the benefit of patients receiving care. There were multiple Clinical Nurse Specialists who supported teams and patients in specific areas, bringing their own expertise and knowledge to develop innovative ways of improving services.
- The trust was committed to developing seven-day services throughout. Good progress had been made towards this, and plans demonstrated that where this had not been completely rolled out, business cases had been accepted by the board and recruitment was ongoing.

Caring:

- Treating patients with dignity and respect, as well as valuing them as individuals, was evident throughout the organisation and found to be a fundamental part of the culture at Frimley Park Hospital.
- Throughout our inspection patients and their relatives told us how caring staff had been towards them, and how staff had 'gone the extra mile' to support them during their admission to hospital. We also witnessed exemplary care being given on many wards.
- Gaining feedback from patients and their relatives was a priority and was used by the trust to improve the care that was delivered. The trust was above the national average in the national Friends and Family test, both in terms of those recommending the hospital to others and in the response rate.

Responsive:

- We saw multiple examples of how services had changed the way they delivered care – either through feedback or by working with the local community to develop the service.
- In areas where there were problems with the flow of patients, there was evidence of inter and intra departmental working to try and improve patient pathways. We witnessed many innovative solutions and saw examples where they had learned from other trusts that had experienced similar difficulties.
- The trust had worked hard to embrace patients who were more vulnerable or had increased needs. There was good support for patients living with dementia or a learning difficulty, and the trust had worked with the local Nepalese community to improve methods of communication.

Well-led:

- Staff engagement at the trust was impressive. The CEO led from the top with a clear mantra that staff worked 'for Frimley' not 'at Frimley' and the concept of the 'Frimley Family' was felt throughout the inspection. Staff were encouraged to, and rewarded for, improving patient experience and therefore at all levels staff reported feeling empowered to develop their own solutions to enhance their services. There was a strong sense of support and alignment between clinicians and managers, both of whom reported working together to achieve their aim of providing outstanding patient care.
- There was a clear vision and values that had been developed with staff to ensure that they aligned with a service they wanted to work for. As a result "committed to excellence; working together; facing the future" was embedded throughout the trust and underpinned fundamental behaviours. The potential acquisition of another provider had been well communicated with staff and at all levels there was confidence that the service provided at Frimley Park Hospital would remain at the current high standard.
- The trust demonstrated a strong patient-centred culture, which considered that public engagement was essential in developing services. The evident strength and depth of leadership at both board and ward level was outstanding, the benefits of which were clearly demonstrated by the consistency of high quality care provided across the domains and throughout the core services and should be congratulated.

In addition to the above, we saw multiple specific areas of good and outstanding practice:

Summary of findings

- The A&E department had been redesigned by taking patients' views into account, and provided an environment that helped to deliver exceptional patient care (including specific dementia-friendly areas).
- The four-hour target was consistently met, and the other core services that worked with the A&E department acknowledged that the target was everyone's responsibility.
- Joint working between the elderly care physicians and the A&E department led to improved patient experience and reduced unnecessary admissions.
- 'Round table' discussions were used as a learning tool, and there were well-developed Mortality and Morbidity (M&M) meetings, which included dissemination to all levels of staff.
- There was a drive to increase incident reporting by all staff groups, especially medical staff (i.e. doctors).
- The management of medical outliers, including the method of communicating with teams, ensured ownership and daily (early) review.
- Specialist advice was available for GPs and the A&E department and rapid access clinics reduced unnecessary admissions.
- Theatre utilisation had improved, and resulted in a cancellation rate of 0.6% between October 2013 and June 2014.
- There were communal dining areas on the orthopaedic wards.
- There was a high standard of care provided for patients at the end of their life, and we saw that staff went to great lengths to respect and accommodate the wishes of patients and their families, including the use of the 'Time Garden'.
- The trust used and audited the trust wide 'Personalised Care Plans for the Dying Patient' in place of the previously used Liverpool Care Pathway.
- The A&E department used memorial boxes for recently bereaved relatives and contacted them six weeks following the death of a relative.
- The ophthalmology service had received a 'Clinical Service of the Year' award from the Macular Society
- Joint working with specialist providers allowed patients to attend outpatient clinics closer to their home rather than having to travel to another provider further away.

However, there were some very limited areas of poor practice where the trust needs to make improvements.

The trust should:

- Review nursing staffing levels and skill mix in paediatrics (services for children).
- Ensure paediatric staff have the necessary skills to identify and manage the deteriorating child.
- Review how training data is recorded within paediatrics, to ensure that records are accurate.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Outstanding ☆	Overall, we rated the Emergency Department (ED) as outstanding. The culture of the team working within the department was one of cohesiveness, with staff displaying a very high level of professionalism and enthusiasm for the work they did. Our discussions with staff, and a review of over 150 individual pieces of evidence, revealed that there was an open and transparent culture within the department with regard to the management of risk. Staff were prepared to report incidents and accidents; incidents were investigated impartially, with a high emphasis placed on quality and service improvement. Although patients were waiting marginally longer to be seen by a clinical decision maker when compared to College of Emergency Medicine standards, the ED at Frimley Park Hospital was one of only a small number of hospitals to consistently achieve the government's 95% target for admitting, transferring or discharging patients within four hours of their arrival in the ED during each quarter for the previous two years. Furthermore, staff spoke positively about having the opportunity to recommend new ways of working to help improve the overall effectiveness of the department. Staff had recognised that the current process of streaming was not perhaps as effective as it could be. We found evidence that suggestions had been made by junior members of the team which would further reduce the time it took for patients to be assessed and to be seen by a clinical decision maker. The clinical effectiveness of the emergency department varied depending on the presenting complaint of patients. Where the service was seen to be performing in low to median quartiles when compared nationally, the department was working to improve its overall performance. We reviewed evidence which demonstrated that the department had improved its management of neutropenic septic patients during 2014. However, where improvements had been made in specific areas such as pain management, we noted that these improvements had not always been sustained; this had already been acknowledged by the trust and action plans were in place to resolve these issues.

Summary of findings

Feedback from patients and their relatives regarding the care they received while using the service was consistently positive. Where people had cause to complain, the senior management team had processes in place for meeting with complainants to address their concerns and to offer resolutions, as well as ensuring improvements were made to the overall service. Staff were observed to engage with patients in a compassionate and caring manner.

There were distinct subtleties with regards to the way staff considered their patients. For example, despite the fact that the majority of patients using the ED were only present in the department for no more than four hours, staff were seen to provide holistic care to people; people were referred to by name and not by condition or cubicle number. Examples of comments made by patients included "It is not possible to put a value on what was done for me in A&E", "They [nurses and doctors] listened and were 100% professional yet still personal and friendly" and "Your complete emergency department were not only extremely efficient but caring, empathetic, reassuring and speedy. The care I received was exemplary… Every single person that we came across in this hospital has given us outstanding customer care. They are all an enormous credit to you [Chief Executive] and to the NHS".

Careful consideration had been given to the design and layout of the ED during a refurbishment in 2012. Senior members of the ED team reviewed a range of existing EDs and incorporated innovative designs and ideas as part of their refurbishment plan. Staff visited internationally renowned trauma EDs in an attempt to learn and introduce new ways of working, with the ultimate goal of improving the overall quality of care patients could expect to receive when they visited the ED at Frimley Park Hospital.

Consideration had been given to the ageing population to which Frimley Park Hospital serves. Examples included the design of two majors cubicles so that they were "dementia friendly". A bariatric cubicle was included in the re-design on the ED to meet the anticipated and evolving obesity epidemic. Patients presenting with gynaecology complaints could be cared for and receive treatment in a cubicle that was suitably designed so as to protect people's privacy and dignity.

Summary of findings

Medical care

Outstanding ☆

Overall we rated medical care as outstanding. Medical care provided at Frimley Park Hospital was rated as good for safety, as patients were protected from avoidable harm and abuse. Incidents were reported, learned from and in general fed back to staff. The trust was aware of areas in which it needed to improve (such as falls) and there were established work streams to improve harm free care. The department was clean and there was an active infection control and prevention team who audited practices regularly. The trust used its own early warning score (known as the Medical Emergency Team (MET) score) which again was well audited, and, as well as a Critical Care Outreach Team (CCOT), staff could call the Medical Emergency Team if they had concerns regarding a patient's condition. With the exception of one ward, all wards were well staffed and frontline staff told us they felt confident that they could increase their numbers if their acuity or dependency changed and that this would be supported by their senior managers. There was increasing consultant presence on site from 8am to 12 midnight seven days a week and the number of junior doctors on the wards out of hours had been increased in response to the increased number of medical patients within the hospital.

Medical care services at Frimley Park were rated as good in terms of delivering effective care. There was evidence of easily accessible guidelines on the trust intranet and specific audit checklists had been developed for two conditions which have been raised nationally as a potential area in which care needs to improve. The Summary Hospital-level Mortality Indicator (SHMI) for the trust remains within expected levels and its readmission rate is better than the national average. National audits were contributed to as expected, and we were given evidence of changes made by specialities in response to their outcomes. We witnessed strong and respectful multidisciplinary team working during our inspection and this was corroborated by feedback from all disciplines spoken with. Enhancing seven-day services was demonstrated to be a priority for the medical directorate and, although this was not yet fully in place at present there was a clear and achievable business case in progress.

We rated the medical care services outstanding for caring. This was because a caring culture was felt to be fully embedded throughout the medical directorate and

Summary of findings

throughout our inspection we witnessed exemplary patient centred care being given. Wards felt calm despite some being very busy and the nursing staff were seen to be relaxed and cheerful whilst undertaking their work, taking the time to consider individual patient's needs. We heard very few buzzers sounding throughout our visit, and those we did were answered very quickly. Interactions between staff and patients appeared natural and easy-going - communication was respectful but friendly. All relatives we spoke with praised the staff and the standard of care that their relative had received.

Medical care provided at Frimley Park Hospital was responsive to patients' needs. In common with all acute trusts, Frimley Park Hospital struggled with the management of flow through the hospital due to the significant rise in emergency attendances and subsequent admissions. Consistent with the national picture, this was largely felt in the medical division. Significant work had been undertaken to reduce the number of unnecessary admissions in terms of developing robust ambulatory pathways and providing geriatrician input to the Emergency Department (ED). Achievement of the four-hour target was seen as much as the responsibility of the medical teams as the ED and joint admission proformas had been developed to allow flex in the admission pathway when either team was particularly stretched. Equally extensive work had been undertaken to improve discharge planning from both a medical and allied health professional standpoint seven days a week. There were still ongoing issues with the number of patient moves (and those occurring out of hours), and patient outliers; both of these were escalated to the chief nurse on a weekly basis. Following a previous inspection by CQC, there was increased visibility of the work being undertaken to improve the experience of patients admitted who were living with dementia.

We rated medical care services outstanding in terms of being well-led. There was a clear vision and strategy for the service, which, despite the potential for uncertainty regarding the acquisition, was well developed and well understood throughout the department. The behaviours and actions of staff working in the division mirrored the trust values of 'Committed to Excellence, Working Together, Facing the Future' of which we saw multiple examples of during our inspection. There was evident

ownership of services and patient-centred care was clearly a priority. Risks (and potential risks) were identified early and discussed openly and there was a governance structure in place that allowed formal escalation where appropriate. The trust (and therefore directorate) welcomed views and input from staff and the local community allowing for a real sense of engagement and therefore empowerment from those involved in the services to improve the quality of care being provided.

Surgery

Outstanding ☆

Overall we rated surgical services outstanding. Patients who required surgical interventions were managed safely and effectively in accordance with recommended professional guidance. Procedures were in place to continuously monitor patient safety. There were sufficient numbers of skilled and knowledgeable staff to safely meet the needs of patients. Knowledge of the learning from training was demonstrated through the staffs' attention to safe practices and adherence to hospital policies. The environment was suitably clean and the equipment needed to deliver care was readily available. Arrangements were in place to access prescribed medicines, including pain relief, and medicines were managed safely.

Patients' needs had been assessed and reviewed. Records were completed for each stage of care and treatment given, and the consent was sought from patients or their advocate. Arrangements were in place for emergency care. Staff had access to consultant-led care for advice and guidance and there was access to diagnostic services and operating theatres outside of normal working hours. Surgeons, anaesthetists and clinical staff followed professional guidance, local policies and procedures. The multi-disciplinary team shared responsibility for delivering people's treatment across all seven days. Surgical outcomes were monitored and information was communicated through the governance arrangements to the trust board.

Patients described their experiences positively, such as, "I have had excellent care on every ward. I have been told all about my progress" and "staff asked what I wanted to be called and offered help and support, and they can't do enough". Patients told us that staff respected their privacy and dignity. The majority of staff

Summary of findings

were observed to be kind, caring and attentive to people's needs. We did hear confidential information being discussed as part of the nurse handover between shifts, which some patients may not have liked. Patients told us they had been given information by doctors and nurses. Information was accessible in a range of formats. The nutritional needs of patients were being assessed and people's religious, cultural and medical dietary needs were met. Although there were some bed capacity issues at times which resulted in surgical patients not being placed on the most appropriate wards, there were arrangements in place to ensure that the right surgical expertise led on their care, and clinical decisions were made responsibly. People who had particular physical or mental health needs were supported by staff who had been trained in these areas, including care needs associated with dementia. Although very few complaints had arisen directly from people's experiences of using the surgical services, there were arrangements in place to respond to complaints in accordance with a local policy.

The surgical services were led by a highly committed, enthusiastic team of staff, each of whom shared a passion and responsibility for delivering a first class service. Staff described leadership as "excellent" and "visible". Staff understood the ethos of the service and the corporate values, and demonstrated a commitment to delivering a quality service to the patients. Governance arrangements enabled the effective identification of risks, monitoring of such risks and the review of progress on action plans. Regular detailed reporting enabled senior managers and representatives of the trust's board to be aware of performance and where improvements had positively impacted on service delivery. The views of the public and stakeholders had been actively sought. The surgical division was engaged in a number of research trials and had contributed to the body of knowledge in surgical specialties. Trainee doctors considered the trust to be an excellent place to gain experience in surgery and reported effective supportive networks.

Critical care **Outstanding** ☆

Overall we rated critical care services outstanding. Patients we spoke with told us of the "good reputation" the service had in the locality and also that they felt "very safe" when using its facilities.

Summary of findings

Patients had access to a bereavement service and annual memorial service to remember their loved ones. The unit had implemented the use of patient diaries and a psychology service was provided. Relatives of patients who remained on the unit for more than one week had a meeting with the matron of their service to ensure any concerns they had would be addressed.

The unit delivered a consultant-led service with two consultants providing medical cover. One consultant was solely dedicated to being on the unit from 8am until 10pm daily. Another consultant provided support to the critical care outreach team and covered the unit on an on-call basis from 10pm until 8am. There were resident facilities provided for consultants who lived more than the recommended 30 minutes away from the hospital. There was nine hours of on-site consultant cover provided at weekends. The unit did not use locum doctors to cover unexpected vacancies. Medical oversight of the MADU was primarily by respiratory consultants with support from their intensive care colleagues when required.

Use of agency nursing staff was below the acceptable minimum rate set by the trust, and all agency staff were subject to a strict recruitment and induction process which mirrored the trust's own recruitment policy. The unit had also rolled out an advanced Critical Care Practitioner training programme, one of very few nationally and the first regionally.

All aspects of care delivered in the unit were audited and reviewed to enable continuous improvements. The unit had implemented extra quality and safety measures to ensure it was delivering a high quality service in line with national guidance. The unit could demonstrate that it was achieving low mortality rates and good patient outcomes when compared to other units of a similar size. We found an open and transparent approach to incident management and a real focus on learning from these events through root cause analysis and peer review processes. There were continuous data submissions to national audits and participation in research programmes on the unit.

The unit was innovative. For example, it had implemented cardio pulmonary exercising testing and Intra-aortic balloon pumps. It regularly contributed to the CCN (Critical Care Network), RCN (Royal College of Nursing) and BACCU (British Association of Critical Care Units).

Summary of findings

We found there was a real commitment to delivering multidisciplinary care and the nursing staff worked flexibly to ensure that a quality service could be delivered safely during busy times. Staff felt valued and supported by their teams and by senior management. They told us they received appropriate training to enable them to meet people's individual care needs. Staff discussed the continuous learning culture on the unit and how they felt supported to engage in continuous personal development.
Staffing levels were continuously reviewed using the unit's staffing acuity tool and we found the staffing levels to be adequate to deliver the service.
The environment was cleaned to a high standard and the trust's infection control policy was being complied with. The unit demonstrated safe medication management and we saw adequate supplies of equipment to meet patients' care needs.

Maternity and family planning

Good

Overall we rated maternity services as good. The maternity department provided safe and effective care in accordance with recommended practices. Outcomes for women using the service were continuously monitored and where improvements were required action was taken. Staff were confident in reporting incidents, knowing these would be reviewed and lessons learned would be shared.
There were occasions where bed flow and capacity interrupted the provision of services to women. This meant that on occasion women were required to have their planned induction of labour postponed.
Resources, including equipment and staffing personnel, were sufficient to meet the needs of women although the midwife-to-women in labour ratio was lower than the recommended levels. Staff received the necessary training and assessments of their competencies so they could respond to women's treatment and care needs. Midwives had supervision of their practice and staff had opportunities to get feedback on their performance as well as developmental opportunities.
The individual needs of women were taken into account in planning the level of support throughout their pregnancy. Feedback from women and their families was positive about the service they received, the level of care and compassion and respect for their dignity and privacy.

Summary of findings

Staff said that there were clear lines of accountability within the maternity department and the good leadership was a positive aspect of the working environment and culture. Staff were clear about their roles and responsibilities and had a commitment to working in a manner that reflected the values and ethos of the trust.

Services for children and young people

Good

Overall we rated the services for children and young people as good. We found children's services to be generally safe. However, we had concerns about nursing staffing levels and skill mix. For example, it had been identified as part of the annual clinical governance review that during periods of limited staffing, there had been an increase in medication incidents.

There were procedures in place to manage the deteriorating patient although the trust had identified that additional work was required to ensure that staff had the necessary skills to both identify and manage the deteriorating child.

Children's services followed national evidence-based care and treatment and carried out local audit activity to ensure compliance.

Children and those close to them, such as their parents or carers, were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. Leadership within the service was strong with a mostly cohesive culture. There was evidence of public and staff engagement as well as innovation within the service.

Services for children and young people followed the trust's incident reporting system and demonstrated that learning from incidents that took place there. Perinatal and clinical governance meetings were held and staff were able to demonstrate that learning from these meetings was taking place.

The children and young people's service was provided in a clean environment. Emergency equipment was checked in line with trust policy and was readily accessible and available.

End of life care

Outstanding

Overall we rated end of life care as outstanding. We found that Frimley Park Hospital was providing an exemplary quality of care to people approaching the end of their life. The few areas where there was potential for improvement had been identified and we saw evidence that work was in progress to make the service even better.

Summary of findings

The trust's End of Life Care (EOLC) Steering Group, which was responsible for the overall monitoring of the provision of EOLC, was established in 2008. It had developed policies and procedures to support end of life care and had a diverse multi-disciplinary membership from both the trust and local community. The EOLC Steering Group was chaired by the Clinical Director for Surgical Services, which meant that the trust strategy for end of life care was disseminated well across all services and we found that there was good 'buy in' to the end of life policies from staff working outside the SPCT.

The hospital's palliative care team saw approximately 1,028 patients in 2013/14. Of these, 51% were non-cancer patients, which showed a good balance between cancer and non-cancer patients being provided with the specialist services of the palliative care team. We were told that 45% of patients who died at the trust were referred to the specialist palliative care team, which compares well with the national average of fewer than 40%. Where people received specialist palliative care input, less than a quarter (23.9%) died in hospital compared to national data for all deaths that showed 51.5% of people died in hospital nationally. This means that the good access to the expertise of the SPCT, coupled with a robust discharge policy, allowed more people to die where they wanted and reduced both the length and frequency of admissions for end of life care.

The first national VOICES survey of the bereaved (2012) found that 71% of people wanted to die at home and the trust's staff talked with enthusiasm about their proactive stance in getting people home to die if at all possible. This was supported by a strong rapid discharge policy that was sufficiently resourced to make it workable. A strong culture of enabling rapid discharge supports people and their families in their desire to die in their home surrounded by the people they love and within a familiar environment that they retain more control over. We were told that the shortest recorded discharge was just 45 minutes but that this was not the norm; a one-day target for making the necessary arrangements for a safe discharge was more usual.

The trust had implemented the AMBER care bundle system, which provided a systematic approach to manage the care of hospital patients who were facing an uncertain recovery and who are were at risk of dying in the next one to two months.

Summary of findings

A review of the data showed that the trust had robust policies and monitoring systems in place to ensure that it delivered good end of life care. However, it was the direct observation and conversations with staff, relatives and patients that made us judge the care outstanding. Individual stories and observed interaction provided assurance that staff of all grades and disciplines were very committed to the proactive end of life care agenda set by the board. One healthcare support worker said, "Is it odd that I enjoy caring for people at the end? I don't mean I want them to die, because I have usually got to know them and care about them and their families, but I am really proud of the good care we give and how comfortable we make people. It is nice knowing you couldn't possibly do any more for them."

A porter told us that all his team treated the people who had recently passed away on the wards as if they were "our own nan or mum. We make sure we look after their dignity and that they are comfortable. Most of us talk to them about where they are going and explain what the mortuary will be like and that their fridge will be cold. It makes our job better if we do it properly and kindly".

We spoke with many people who were approaching the end of their life and some of their relatives. All were extremely positive about the care and support they received at Frimley Park Hospital. People told us their symptoms were very well managed and that nothing was too much trouble for staff. We observed kind and gentle interactions between staff and patients and could see that the people we visited in their rooms were clean, comfortable and hydrated. We sat with one elderly person who was being cared for in bed, in a single room, as they were expected to die shortly. This person slid their hand out of the covers to hold our hand and said they weren't really frightened as everyone was so kind to them. They said their grandchildren had visited and bought them lovely presents that were displayed around the room. Then they showed us the bright nail polish that they said one of the night nurses had used when they gave them a manicure. They said, "I used to like dancing and parties and my nails make me smile and remember those days".

We asked numerous staff about the care and support they received when people died. Many acknowledged that it could be emotionally difficult when caring for people in their last days and hours, but all said they had excellent support and told us who they could turn to at

these times. Staff mentioned their teams supporting each other, approachable and supportive ward colleagues, input from clinical nurse specialists and senior managers and the chaplaincy team. One junior nurse told us about a recent traumatic death where she had been upset after caring for the patient. They said, "One of the consultants took me to the quiet room and sat with me for ages explaining why the person suffered the symptoms they did and that they would not have been aware of the symptoms. He spent ages answering all my questions and making sure I was OK". Good staff support is essential to enable the staff to provide effective end of life care. Well cared-for staff meant that they felt strong enough to provide good care in difficult circumstances and we found that the good staff support available enabled them to provide effective end of life care.

Staff across the hospital were justifiably proud of the quality of end of life care they provided; all the staff smiled easily as they went about their work. They talked about, "Loving their work" and "Really enjoying caring for elderly people". Senior managers were effusive in their praise of the whole staff group and this had enabled ownership of care quality by the whole hospital staff team.

Outpatients

Good

Overall we rated outpatients as good. Patients attending for outpatient appointments at Frimley Park Hospital and other clinic sites provided by the trust received good care. The premises were, with the exception of the fracture clinic, appropriate for the service they were providing. Where issues around capacity had been identified, the trust had responded to reduce the impact on patients.

We did identify some minor shortcomings in care practice by individual staff members, but this was not widespread.

Staff were kind, attentive and spent time ensuring patients understood what their appointment involved and what their treatment plan was. Where necessary, people were assisted to make follow-up appointments and to access the hospital transport.

The trust generally compared favourably with other trusts nationally in meeting waiting time and treatment targets, and in ophthalmology was a market leader, having been presented with an award as Clinical Service

Summary of findings

of the Year by the Macular Society. There was scope for a more consistent and sustained level of achievement in meeting targets and delivering an above average service.

Leadership at all levels was visible and engaged with operational staff. Staff reported feeling supported and encouraged to innovate. There was some uncertainty in response to our questions by the nurse in charge of the main outpatients department, but we accepted they had been thrust into the position by the death of a senior colleague a very short while before the inspection. The impact of the loss of a close colleague was clearly felt throughout the department but this did not impact significantly on the delivery of patient care. The Head of Nursing for the outpatients department said, “We put patients first. We work as a team. The patient pathway through the outpatients department links with so many departments and we communicate well with them. We always look ahead and we always deliver a level of care we would expect our families to receive”. Our observations found this to be true.

Outstanding ☆

Frimley Park Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

Contents

Background to Frimley Park Hospital

Frimley Park Hospital NHS Foundation Trust has been a foundation trust since 1 April 2005. It employs almost 3,700 whole time equivalent staff and has around 750 beds. The trust's turnover is £290million and they have been in surplus since 2005.

We carried out this follow-up inspection in addition to our comprehensive inspection in November 2013, as Frimley Park Hospital was inspected during a pilot period when shadow ratings were not published. In order to publish a rating we needed to update our evidence and inspect all core services and the well-led question trust-wide. Because we had inspected the trust so recently (in November 2013) we did not repeat some parts of our usual inspection process. This included the unannounced visit (which took place at night) and the public listening event. At the public listening event in November we heard directly from about 100 people about their experiences of care.

At the time of this inspection there was a stable executive team. The CEO had been in post since 1989 and other executive members joined between 1991 and 2013. The Chair had been in position since April 2006 and the remaining non-executive directors had been in position since between 2006 and 2013.

Detailed findings

Frimley Park Hospital NHS Foundation Trust hosts a Ministry of Defence Hospital Unit with military medical, surgical and nursing workforce fully integrated into the NHS staff.

The trust is proposing to acquire Heatherwood and Wexham park Hospitals NHS Foundation Trust during 2014 and at the time of the inspection were progressing through the transaction.

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of eight on 10 and 11 July and the team of 22 on 8 and 9 August 2014 included CQC senior managers, inspectors, doctors, nurses, pharmacist, patients and public representatives, Experts by Experience and senior NHS managers.

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 inspected the following eight core services at the Frimley Park Hospital:

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

Prior to the announced inspection, we reviewed a range of information we held from our inspection in November 2013 when we asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch. At this follow-up inspection we liaised with a proportion of these stakeholders.

We carried out the follow up inspection in two parts. We inspected A&E and Maternity on 10 and 11 July 2014. We inspected medicine, surgery, critical care, paediatrics and young people, end of life care and outpatients on 7 and 8 August 2014.

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

Facts and data about Frimley Park Hospital

Context

- Foundation Trust since 1 April 2005
- Approximately 750 beds
- Serves a population of around 400,000
- Employs around 3,700 whole time equivalent members of staff

Detailed findings

Activity

- Around 33,000 inpatient emergency admissions per annum
- Around 57,000 inpatient elective admissions (including day case activity)
- Around 350,000 outpatient attendances per annum
- Around 104,000 A&E attendances per annum
- Around 5,500 births per annum

Intelligent Monitoring – (March 2014)

- Safe: Items = 8, Risks = 1, Elevated = 1, Score = 3
- Effective: Items = 31, Risks = 0, Elevated = 0, Score = 0
- Caring: Items = 21, Risks = 0, Elevated = 0, Score = 0
- Responsive: Items = 10, Risks = 0, Elevated = 0, Score = 0
- Well led: Items = 24, Risks = 2, Elevated = 0, Score = 2
- **Total:** Items = 94, Risks = 3, Elevated = 1, Score = 5

Key Intelligence Indicators

Safety

- One never event in last 12 months – retained swab in maternity services
- STEIS 59 Serious Untoward Incidents (April 2013 - March 2014)
- Infections
  - C-difficile: within expectation
  - MRSA: within expectation

Effective

- HSMR: 88 (better than national average)
- SHMI: 89 (better than national average)

Caring

- Friends and Family Test
  - Average score for both inpatients and A&E are better than the national average for 2012/13
  - Response rates for both inpatients and A&E are better than the national average for 2012/13
- Cancer Patient Experience - In the top 20% of all trusts nationally for 25 of the 69 questions
- CQC Adult Inpatient Survey - Trust scored 'within expectations' in all 10 areas

Responsive

- A+E 4 hour target: Consistently met the 95% in the previous 12 months
- Referral to treatment: Consistently met the admitted and non-admitted pathways
- Cancer 2 week wait: Consistently met the national target
- Cancer 31 day wait: Consistently met the national target
- Cancer 62 day wait: Consistently met the national target

Well-led

- Staff survey 2013:
  - Consistently been in the top 20% for over ten years with 0 questions in the lowest 20%
    - 88% recommend the hospital as a place to receive treatment (better than average)
    - 77% recommend the trust as a place to work (better than average)
    - 83% of staff say the care of patients their top priority (better than average)
    - 96% extremely likely or likely to recommend as a place to work (better than average)

Inspection history

Comprehensive new inspection in November 2013 during wave one. Ratings were not published.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	☆ Outstanding	Not rated	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical care	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Surgery	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Critical care	☆ Outstanding	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients	Good	Not rated	Good	☆ Outstanding	Good	Good
Overall	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both accident and emergency and outpatients.

Accident and emergency

Safe	Outstanding ☆
Effective	Not sufficient evidence to rate ●
Caring	Good ●
Responsive	Outstanding ☆
Well-led	Outstanding ☆
Overall	Outstanding ☆

Information about the service

The emergency department (ED) at Frimley Park Hospital provides a 24-hour, seven-day a week service to the local population. In 2013/2014 the adult ED saw 77,457 patients of which 45,146 were classified as major/resus attendances and 32,311 as minor attendances. The paediatric ED was responsible for seeing and treating 24,747 children during the same time period.

Patients present to the department by walking into the reception area or arriving by ambulance. If a patient arrives in the department on foot, they are booked in at reception before being seen by a senior nurse who 'streams' them to the appropriate area. If a patient arrives by ambulance, they are initially assessed by a senior nurse within the ambulance handover area. Patients are then transferred to the main ED.

The emergency department at Frimley Park Hospital (ED) consists of 38 beds with an additional five assessment cubicles. There are 26 major cubicles, a four bed minor injury unit, eight resuscitation area trolleys and a further 13 beds situated in the Emergency Department Observation Unit (EDOU). The reception, majors, resuscitation and assessment areas had all been refurbished in 2012.

The ED is a member of a regional trauma network and is a designated trauma unit. The hospital also provides acute stroke services and coronary intervention for acute heart attacks.

During our inspection, we spoke with 22 members of staff from both the main adult ED and staff working in the children's ED. We spoke with three families, including parents and children who were present at the children's ED and also with 13 patients who were present in the main adult ED.

Accident and emergency

Summary of findings

Overall, we have rated the Emergency Department (ED) as outstanding. The culture of the team working within the department was one of cohesiveness, with staff displaying a very high level of professionalism and enthusiasm for the work they did.

Our discussions with staff, and a review of over 150 individual pieces of evidence, revealed that there was an open and transparent culture within the department with regard to the management of risk. Staff were prepared to report incidents and accidents; incidents were investigated impartially, with a high emphasis placed on quality and service improvement.

Although patients were waiting marginally longer to be seen by a clinical decision maker when compared to College of Emergency Medicine standards, the ED at Frimley Park Hospital was one of only a small number of hospitals to consistently achieve the government's 95% target for admitting, transferring and discharging patients within four hours of their arrival in the ED, during each quarter for the previous two years. Furthermore, Staff spoke positively about having the opportunity to recommend new ways of working to help improve the overall effectiveness of the department. Staff had recognised that the current process of streaming was not perhaps as effective as it could be. We found evidence that suggestions had been made by junior members of the team which would further reduce the time it took for patients to be assessed and to be seen by a clinical decision maker.

The clinical effectiveness of the emergency department varied depending on the presenting complaint of patients. Where the service was seen to be performing in low to median quartiles when compared nationally, the department was working to improve its overall performance. We reviewed evidence which demonstrated that the department had improved its management of neutropenic septic patients during 2014. However, where improvements had been made in specific areas such as pain management, we noted that these improvements had not always been sustained; this had already been acknowledged by the trust and action plans were in place to resolve these issues.

Feedback from patients and their relatives regarding the care they received while using the service was consistently positive. Where people had cause to complain, the senior management team had processes in place for meeting with complainants to address their concerns and to offer resolutions, as well as ensuring improvements were made to the overall service. Staff were observed to engage with patients in a compassionate and caring manner.

There were distinct subtleties with regards to the way staff considered their patients. For example, despite the fact that the majority of patients using the ED were only present in the department for no more than four hours, staff were seen to provide holistic care to people; people were referred to by name and not by condition or cubicle number. Examples of comments made by patients included "It is not possible to put a value on what was done for me in A&E", "They [nurses and doctors] listened and were 100% professional yet still personal and friendly" and "Your complete emergency department were not only extremely efficient but caring, empathetic, reassuring and speedy. The care I received was exemplary… Every single person that we came across in this hospital has given us outstanding customer care. They are all an enormous credit to you [Chief Executive] and to the NHS".

Careful consideration had been given to the design and layout of the ED during a refurbishment in 2012. Senior members of the ED team reviewed a range of existing EDs and incorporated innovative designs and ideas as part of their refurbishment plan. Staff visited internationally renowned trauma EDs in an attempt to learn and introduce new ways of working, with the ultimate goal of improving the overall quality of care patients could expect to receive when they visited the ED at Frimley Park Hospital.

Consideration had been given to the ageing population to which Frimley Park Hospital serves. Examples included the design of two majors cubicles so that they were "dementia friendly". A bariatric cubicle was included in the re-design on the ED to meet the anticipated and evolving obesity epidemic. Patients presenting with gynaecology complaints could be cared for and receive treatment in a cubicle that was suitably designed so as to protect people's privacy and dignity.

Accident and emergency

Are accident and emergency services safe?

Outstanding ☆

There were systems to protect patients and maintain their safety. There were adequate staffing levels to provide safe care to patients. In addition, staff received the necessary training to enable them to carry out their roles effectively.

Incident reporting was common practice throughout the department and there were examples that staff learnt from incidents, near misses and errors.

The department had processes in place for assessing patients when they first presented to the department, and also for monitoring patients when they remained in the department for extended periods of time; patients were escalated to the appropriate clinician as required to ensure they received timely care and treatment.

Incidents

- The trust reported 526 incidents (rated as harm which was moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between April 2013 and 31 August 2014. Fifteen incidents were reported via the ED, of which 2 were graded as severe and 13 graded as moderate harm (incidents are classified by the degree of harm to patients)
- The adult ED reported 2 Serious Incidents Requiring Investigation (SIRI) during 2013/2014. Both incidents were investigated and there was evidence of learning as a result of both incidents. Seven staff that we spoke with (from different grades of nursing and medical staff) were able to describe the 2 SIRIs that had occurred during 2013/2014; they were further able to describe the actions taken by the department to help to mitigate the risk of such incidents occurring again in the future.
- The findings and lessons learnt from the 2 SIRIs were shared with the trust wide patient safety committee in order that the lessons could be disseminated across the trust.
- Furthermore, in order that learning from incidents which had occurred within the ED could be disseminated across different departments, "round table" discussions were used to facilitate open discussions between a range clinical staff and health care professionals.
- The ED had recently appointed a consultant physician with a professional background in patient safety; this individual was the identified department lead for safety.
- The majority of the 22 staff that we spoke with reported that there was an "open door" culture; junior staff spoke positively about being able to raise concerns directly with the clinical and nursing leads for the ED.
- All incidents were reported through a centralised system called Datix. Senior nurses and consultants reviewed the incidents reported and analysed the data to identify any trends. Learning from incidents was disseminated to the staff team. Trends of incidents for 2013/2014 included pressure ulcers, patient falls and security issues attributed to inebriated and/or aggressive patients.
- 37 incidents relating to security issues had been reported in 2013/2014. As a result of the increase in incidents relating to violent and aggressive patients, all nursing staff have since received conflict resolution training.
- In the NHS Staff Survey 2013, 11% of staff reported that they had experienced physical violence from patients, relatives or members of the public in the last 12 months; this was better than expected when compared to other acute trusts nationally, whereby, on average, 15% of staff had reported that they had experienced physical violence from patients, relatives or members of the public in the last 12 months.
- Specific examples of changes to practice as a result of incidents included updating the departments electronic patient system to help staff to identify patients on high risk drugs such as methadone. This has helped staff to ensure that specific medications are administered promptly so as to enhance the patients' experience.
- Additional changes to practice include the early recognition of patients who have recently received, or who are currently receiving chemotherapy treatments. This enables staff to be able to identify patients who may be at risk of neutropenic sepsis so that appropriate treatment can be commenced within the correct timeframe, as recommended by the College of Emergency Medicine (CEM) and The NHS National Cancer Peer Review Programme.
- Between 2011 and 2014 there had been a year-on-year increase in the number of incidents reported by the ED (see below).

Accident and emergency

Number of incidents reported vs total number of attendances to the ED:

- Year 2011/2012: Attendances = 103,328, Number of Incidents Reported = 413, Attendance/Incident Ratio = 0.40%
- Year 2012/2013: Attendances = 105,274, Number of Incidents Reported = 460, Attendance/Incident Ratio = 0.44%
- Year 2013/2014: Attendances = 102,204, Number of Incidents Reported = 464, Attendance/Incident

- This increase in incident reporting was reflective of the staff's willingness to report incidents within the ED. Staff that we spoke with reported that they were confident that if they reported an incident, they would receive feedback from the senior management team.
- In the NHS staff survey for 2013, 92% of staff reported that they would report errors, near misses or incidents that they had witnessed in the last month; this was better than expected when compared to other NHS trusts nationally.
- The concept of incident reporting and risk management had been incorporated into the local ED induction for new staff.
- Frimley Park Hospital NHS Foundation Trust was one of 12 NHS trusts to initially sign-up to the NHS England "Sign up for Safety" Campaign, which is a national initiative that aims to make the NHS the safest healthcare system in the world. The senior nursing and medical team within the ED were able to describe the initiative as well as the actions the trust had committed too to help improve patient safety and to reduce the occurrence of avoidable harm by 50% in 3 years.
- Root-cause analysis reports for 2013/2014 demonstrated that no hospital acquired pressure ulcers had been attributed to the care patients received in the ED. This was consistent with the ED's Safety Thermometer which reported that between January 2014 and June 2014 the ED attained 100% compliance with providing harm free care.
- Whilst the department did not hold regular paediatric morbidity and mortality meetings (due to the low frequency with which significant incidents involving the care and treatment of children in the department occurred), there was evidence that the department carried out debriefing sessions for staff following paediatric cardiac arrest scenarios. We reviewed the minutes of one such meeting which took place on 16 May 2014. Of note, the meeting took place one day after the event had occurred; this was noted to be important by the inspection team because a) staff accounts of the incident remained timely and relevant and b) debriefing following paediatric resuscitation is recommended by the UK Resuscitation Council UK because it allows staff an opportunity to "Express any concerns and to allow the team to reflect on their clinical practice" as a means of improving the quality of future resuscitation situations. We found that actions were produced as a result of the meeting although it was noted that timescales were not recorded as part of the action plan and so there was a risk that actions may remain unresolved if the action plan was not monitored.
- Regular Bi-monthly trauma morbidity and mortality meetings and medical morbidity and mortality meetings took place. Outstanding actions from the previous meeting were discussed, and where necessary closed if they had been addressed.

Cleanliness, infection control and hygiene

- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- The ED had nominated link nurses for infection control who were actively engaged in the "Winning Ways – Working together to reduce Healthcare Associated Infection for England" initiative from the Chief Medical Officers office.
- Audit date from the "Winning Ways" audit for May 2014 identified that 100% of mattresses used in the ED were "Intact" and that the inside of all mattresses were free of staining.
- We observed staff appropriately decontaminate patient's skin in line with the trust policy, prior to the insertion of venous and/or arterial catheters. Data from the "Winning Ways" audit demonstrated that in July 2014, 100% of staff whose aseptic non-touch technique was randomly assessed by an infection control link nurse was consistent with local policies and approved techniques.
- Staff washed their hands between each patient and we noted good usage of the hand sanitising gel.
- Hand hygiene compliance audit data provided to us by the trust demonstrated that between April 2013 and June 2014, the adult department regularly attained

100% compliance with hand hygiene practices (May, July, August, September, November 2013, March, May and June 2014). Compliance was noted to be between 96 and 97% in April, June, October and December 2013. Audit data was not available for January and February 2014.

- Within the main adult ED, "Bare below the elbow" compliance was noted to be 100% for almost every month between April 2013 and June 2014 with the exception of April (92%) and June 2013 (90%).
- The paediatric ED consistently attained 100% compliance with both hand hygiene and "Bare below the elbow" between April 2013 and June 2014.
- 'Bare below the elbow' policies were seen to be observed by all staff.
- There had been no reported cases of MRSA or Clostridium difficile within the ED in the last twelve months.
- The children's ED had a process of isolating patients who presented with symptoms consistent with childhood infections including chicken pox and measles.

Environment and equipment

- The department had a range of equipment, which was seen to be clean and well-maintained. Labels were in use to indicate when items of equipment had been cleaned.
- There was an eight bedded resuscitation area, which was clean, tidy and well organised. The resuscitation area had been expanded by 3 beds as part of the 2012 redevelopment.
- The location of the resuscitation bay allowed rapid transfer of patients from the hospital helipad and ambulance bay giving patients quick access to the specialist emergency care team.
- The paediatric emergency department was clean, bright and equipped with children's toys.
- There was sufficient equipment for resuscitating patients, and staff had been trained how to use it. Staff said they carried out equipment checks daily, and we saw this happening in practice.
- Six of the resuscitation bays were set up identically. This helped staff to become familiar with their working environment, so that appropriate equipment was to hand and staff could treat people in a timely manner. Two resuscitation bays had equipment for treating children of all ages.
- The main adult department had a room dedicated to the treatment of people who presented with mental health problems. The room allowed people to be treated away from the busy major's area and was designed to offer people privacy and a degree of security.
- A range of "Point of Care" diagnostic devices were readily available within the ED to allow staff to carry out tests during the initial stages of assessment and to help plan appropriate care and treatment.

Medicines

- There were processes in place for ensuring medications were kept securely. Medication fridges were found to be locked when we randomly checked them. Fridge temperatures were routinely being recorded to ensure that medicines were stored as per the manufactures recommendations.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs.
- Nursing staff in the Paediatric ED routinely administered a select range of medications by utilising patient group directives (PGD's). PGD's are a set of written instructions which allow non-prescribing health care professionals to supply and administer specific medications to patients who meet set criteria. The use of PGD's is underpinned by legislation (Human Medicines Regulations 2012, the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001) and therefore providers need to have robust processes in place to ensure they meet the legislative requirements. It was noted that the use of PGD's had not been routinely reviewed to ensure they remained the most effective way of providing the relevant medication. However, it was reported that the newly appointed sister for the paediatric ED was in the process of addressing this issue and an audit was underway to review the use of PGD's within the department.
- 29 incidents associated with medications were reported during 2012/2013 with one noted as being a "harm" event. Whilst this incident remained under review, the ED management team had considered the incident and had implemented changes to practice including the revision of clinical protocols.
- Text below demonstrates that since 2011, there has been an overall reduction of medication errors occurring within the ED.

Accident and emergency

Reported Medication Errors occurring in the ED

- Year 2011/2012: Attendances = 103328, Number of Medication Incidents Reported = 44
- Year 2012/2013: Attendances = 105,274, Number of Medication Incidents Reported = 31
- Year 2013/2014: Attendances = 102,204, Number of Medication Incidents Reported = 29

- The ED was represented at the Trust Medication Safety Committee which met monthly. This ensured that any changes to medication practices, including medication related alerts from external agencies such as the National Patient Safety Agency could be disseminated to staff in the ED.

Records

- We reviewed 25 sets of care records during the inspection to determine whether the department routinely utilised risk assessments specifically related to slips, trips and falls, mental health assessments and safeguarding.
- Records were found to be complete in each of the 25 cases. Where children had been identified as being at risk, for example where children had presented with mental health concerns, or for those who had "self-harmed", contemporaneous notes had been made by clinical and nursing staff; decisions and treatment plans were clearly recorded and there was documented evidence that the appropriate referrals to safeguard agencies had been made.
- We saw evidence that all patients who were subsequently admitted to the EDOU after having been initially assessed and treated in ED underwent a falls risk assessment. We sampled 15 sets of notes of patients who had been admitted to the EDOU. Each patient, regardless of age (ages of patients ranged from 36 years to 87 years of age) had been assessed to determine whether they were at risk of falling. This demonstrated that the concept of falls risk assessments had been embedded into practice. Additional initiatives to help to reduce the risk of falls included non-slip slippers for patients admitted to EDOU.
- Records were found to be kept securely.
- The trust reported that it had discovered that a lack of standardised electronic patient record keeping had been problematic as healthcare professionals could not always access the most up-to-date information for patients who may have been seen in other departments. ED used its own electronic system, and staff told us that the system met their needs and was easy to use. However, staff from other departments told us that the fact that the system was only used in the ED meant that they had experienced difficulties in accessing patient information in a timely way. We identified a total of six different electronic patient information systems being used across the hospital. Staff told us they would still make entries in the paper patient notes but that comprehensive patient data would be stored electronically.
- A recent audit demonstrated that 90% of patients were admitted to the ward with a copy of their CAS Card (detailing the management of the patient during their stay in the ED).
- 80% of nursing staff and 100% of administrative staff had completed their training in Information Governance at the time of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were available for people with parental responsibility to consent on behalf of children who were not Gillick competent.
- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Staff that were new to the department were provided with training in the form of Safeguarding Vulnerable Adults. This included guidance to staff on the carrying out of a "Mental Capacity Act (2005) – Capacity Assessment".

Safeguarding

- There were appropriate processes for safeguarding patients against abuse. The department also had a multi-disciplinary Safeguarding Children Group, which met twice weekly to discuss recent safeguarding referral forms and ensure that any necessary action was taken.
- The department demonstrated that it had learned from previous safeguarding incidents. For example, it had adapted the electronic patient recording system to remind all doctors to consider the safeguarding of

vulnerable adults, especially those at risk of domestic violence. There were also systems in place for referring children and adolescents to the local Child and Adolescent Mental Health Service (CAMHS).
- Children who presented to the ED having "self-harmed" are signposted to an external support agency "Catch 22" as well as being referred to children services; information was also shared confidentially with school nurses and General Practitioners. A local working arrangement was in place with the local CAMHS service to ensure that this group of children and young people are admitted dependent on the time of presentation to allow for timely assessment by the CAMHS team.
- Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.
- Policies relating to Safeguarding Adults and Children were readily available and accessible. The adult protocol had last been reviewed in October 2013 and the children's protocol had been reviewed in June 2014.
- 100% of children's nurses and 80% of adult nurses had completed child protection training to level 3. All consultants had received training to level 3 in child protection.
- It was noted that in the minutes from the Adult and Paediatric Safeguard meeting that took place on 18 June 2014, "The emergency department have seen an increase in safeguarding referrals and this has raised some serious questions of where education is required".
- The department had a consultant lead for vulnerable adults and another for vulnerable children.
- Junior doctors received training in safeguarding vulnerable children as part of their initial induction to the department.
- The ED had an allocated Domestic Abuse link nurse who attended the regional, multi-agency Domestic Abuse Forum; we saw that feedback and information was disseminated to members of the ED team.

Mandatory training

- Compliance with mandatory training was seen to be good with over 85% of nursing staff having completed their mandatory training in line with trust policies.
- 98% of staff had completed training in both fire safety and manual handling.
- All of the children's nurses working in the ED had completed paediatric life support training.
- 82% of consultants had recently completed training in infection control.

Assessing and responding to patient risk

- Patients arriving by ambulance were initially assessed by a nurse who carried out baseline observations from which a Medical Emergency Team (MET) score was calculated. Children arriving by ambulance were transferred to the children's ED where a Paediatric Early Warning Score (PEWS) was calculated.
- Patients arriving on foot initially checked in with reception. We observed that when some patients presented with minor ailments, the reception staff directed them to the minor's department. For more complex cases, or where the presenting ailment was unclear, or where the patient looked unwell, they were directed to the "streaming nurse" who would initially assess the patient before a decision was made as to where best the patient should be treated.
- Five initial assessment cubicles were available which allowed staff to carry out physical examinations, as well as commencing initial investigations such as the taking of blood samples for analysis or ECGs when patients presented with chest pain. Interventions could also be undertaken such as the administration of analgesia and intravenous fluids.
- There were clear processes in place for monitoring patients. The use of MET and PEWS allowed staff to monitor patients and to identify deteriorating patients. MET scores were viewable on the electronic screen so staff such as the ED nurse-in-charge or lead consultant were aware of any patient who may be deteriorating anywhere in the ED. The process of escalating patients who were scoring high on the MET or PEWS system was displayed throughout the ED and staff were observed to be using the system during our inspection.
- The department was listed as a local Trauma Unit. There were systems in place for the local ambulance service to make contact with the ED in the event that a patient who had sustained trauma was being transferred to the department. We observed on two separate occasions such examples of when trauma patients were being transferred to Frimley Park hospital. We observed how the trauma team worked together in the management of trauma patients; different team members were observed to respond in a timely fashion; roles and responsibilities for each member of the team were clearly communicated, and on each occasion the ED consultant assumed clinical responsibility for the patient in order that the assessment process remained co-ordinated.

Accident and emergency

Nursing staffing

- Staffing in the ED was observed to be good. At the time of the inspection, there were no nurse vacancies.
- The department has had due regard to the College of Emergency Medicine guidance titled "The Way Ahead" dated December 2011, when considering staffing provision across the whole ED. For example, the department had increased the number of band 6 nurses from 14 whole time equivalents to a current 21.79 wte's to allow for senior nurses to be present in the resuscitation area. There were sufficient numbers of band 6 nurses to allow for two band 6's to be available on each shift, 24 hours per day, seven days per week to support junior staff.
- In addition, the department provides an Emergency Nurse Practitioner (ENP) service from 07:45 to 20:15 each day; the ENP's support the minor injuries unit as well as providing a daily dressing's clinic to help reduce the number of patients who require admission to hospital simply for wound dressing management.
- Although the department does not utilise a specific acuity tool, nursing shifts are staggered throughout the day to ensure that there are sufficient numbers of nurses available during peak times.
- The paediatric ED was supported by qualified children's nurses and a newly appointed Band 7 nursing lead had been appointed to the paediatric ED.
- Staff working in the Paediatric ED reported that on occasion, when acutely unwell children were directly admitted to the resuscitation area, waiting times and work pressures increased in the main paediatric ED because a nurse was required to support the resuscitation team.
- Actual staffing levels within the ED were monitored and reported to the Director of Nursing (occasionally referred to as Chief Nurse) and to the Director of Operations on a monthly basis. During May and June 2014 there were three occasions each month when the department had less than 80% of the trained staffed required; however, it was noted that the department mitigated the risk of having insufficient staff by allocating additional care assistants to help support the department.

Medical staffing

- There were 16 consultants employed to support the emergency department. Two consultants were specialists in paediatric medicine and were available between 08:00 and 17:00 each week day. A dedicated junior doctor was allocated to support the paediatric ED each day between 14:00 and 22:00. Junior doctors were supported by the ED lead consultant when no paediatric consultant was available in ED. In addition, junior doctors and nursing staff could access the paediatric registrar who was situated in the hospital 24/7.
- Although the ED did not have a 24/7 consultant-led service, there was direct consultant cover available from 8am to midnight, seven days a week with 'on-call' consultant cover from midnight to 8am.
- There are twice daily consultant-led board rounds in the ED which act to review the department and to provide teaching opportunities for junior doctors and nursing staff. The lead ED consultant was also responsible for reviewing patients in EDOU. We observed the morning round to be supported by the consultant in elderly care. EDOU patients were also reviewed again as part of the 16:00 ward round and again by the ED consultant at midnight.

Major incident awareness and training

- There was a designated major incident store within the department. The department was equipped with a decontamination room.
- The department had a major incident plan which was last reviewed in November 2013.
- Staff that we spoke with had a clear understanding of their roles and responsibilities with regards to major incidents. Staff directed us to the Major Incident Plan and was able to discuss the action cards which formed part of the policy.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The ED had an ongoing programme of auditing, which encompassed both national and local audits; however, it was clear that despite engaging in national audit programmes, improvements in patient outcomes could not always be sustained.

Accident and emergency

Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine, the

National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK.

There was evidence of strong multidisciplinary working, with a noted area of good practice being attributed to the involvement of the Care of the Elderly Physician with regards to the management of patients in the EDOU. This service was fully integrated into the ED and was seen to produce positive outcomes for patients using the service.

Evidence-based care and treatment

- Departmental policies, procedures and guidelines were based on nationally recognised best practice guidance, for example, the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine (CEM). Examples include ED pathway management protocols for patients who present with suspected deep vein thrombosis (DVT) which was based upon the NICE clinical guideline CG144.
- The CEM has a range of evidence based clinical standards which all ED's should aspire to achieve to ensure that patients receive the best possible care to ensure optimal clinical outcomes. The CEM recommends that 100% of patients who present to an ED with signs of sepsis or severe shock should receive a dose of antibiotics prior to leaving the department (within four hours). During 2011/2012, 87% of patients who presented to the ED with signs of sepsis or shock, received antibiotics prior to leaving the ED. This was slightly below the national median result of 89%.
- A Severe Sepsis and Septic Shock Audit dated March 2014 demonstrated that 100% of patients presenting to the ED with signs and symptoms of sepsis had their vital signs taken and recorded during their admission (CEM standard is 100%). In addition, 100% of patients had a blood glucose recorded (CEM standard is also 100%). 33% of patients were reported to have received high flow oxygen (CEM standard 100%), 40% had received an IV bolus (CEM standard 75%) within one hour and 88% prior to leaving the ED (CEM Standard 100%). 63% of patients received antibiotics within 1 hour (CEM standard 50%) and 100% received antibiotics before leaving the ED (CEM standard 100%); which was an improvement on the ED's performance of 2011/2012 (see above).
- The audit identified areas of excellent, good and poor practice. Recommendations on how improvements could be made were summarised as a result of the audit, including the provision of supplementary training to junior doctors.
- The ED continued to monitor the management of patients who presented to the ED and were subsequently managed for neutropenic sepsis. During April and May 2014 a total of 10 patients who were receiving chemotherapy treatments were identified as being neutropenic and septic. 90% of those patients received antibiotics within an hour of arriving in the ED. The remaining 10% of patients received antibiotics prior to leaving the department.
- According to the ED dashboard between April 2013 and March 2014, the ED attained their monthly target (40% between April – September 2013 and 50% thereafter) of scanning patients who presented to the ED with stroke like symptoms within one hour in nine out of the twelve months. However, during the same time period, the ED was only able to attain their monthly target of initiating thrombolysis treatment on eligible patients within 60 minutes of arrival to the ED in two out of the twelve months.

Pain relief

- The ED participated in three CEM audits which included the management of moderate or severe pain; the management of patients presenting in moderate or severe pain caused by renal colic, the CEM Clinical Audit into the Management of Fractured Neck of Femur (FNOF) and Pain in Children.

Renal Colic Performance:

- 74% of patients who presented to Frimley Park Hospital ED during 2012-2013 complaining of pain as a result of renal colic, had a pain scored recorded. This placed the ED between the lower and median quartile when compared nationally. The department did not meet the CEM standard of 100% of patients presenting with moderate or severe pain having a pain score recorded.

- 21% of patients who presented in severe pain with renal colic were provided with analgesia within 20 minutes of arrival. This placed the ED between the lower and median quartile when compared nationally (median was reported as 24% nationally).
- The department was placed between the median and upper quartile for patients receiving analgesia within 30 minutes (41%) and in between the lower and middle quartile for patients receiving analgesia within 60 minutes (63%). The median for patients receiving analgesia within 30 and 60 minutes was reported nationally as 36% and 65% respectively.
- CEM standards recommend that 50% of patients presenting in severe pain with symptoms of renal colic should receive analgesia within 20 minutes, 75% within 30 minutes and 98% within 60 minutes upon arrival to the ED.

Fractured neck of femur:

- 25% of patients who presented to the ED with a fractured neck of femur (FNOF) complaining of severe pain received analgesia within 20 minutes (CEM standard is set at 50%). This was a minor improvement on the trusts performance of 2009 when 22% of patients received analgesia within 20 minutes.
- 38% of patients received analgesia within 30 minutes (CEM standard is set at 75%). This was a decline in performance when compared to 2009 data although the trust was above the national median of 29%.
- 63% of patients received analgesia within 60 minutes. We noted that when compared to the audit data of 2009, there had been a decline on the trusts performance of 2009 when 72% of patients received analgesia within 60 minutes. However, it is important to note that that the trust was placed above (better than) the national median quartile for this standard.

Trust Performance against CEM standard for the administration of analgesia within a set timescale

- Analgesia provided within = 20 minutes, CEM Standard = 50%, 2012 Trust Performance = 25%, National Median Result = 15%
- Analgesia provided within = 30 minutes, CEM Standard = 75%, 2012 Trust Performance = 38%, National Median Result = 29%
- Analgesia provided within = 60 minutes, CEM Standard = 98%, 2012 Trust Performance = 63%, National Median Result = 56%

- A supplementary audit was provided to the inspection team as part of the information we requested from the trust. We found that a number of improvements had been made in the timeliness of analgesia being provided to patients who reported or who were assessed as being in severe pain. 37.5% of patients (an increase of 12.5% on the 2012 data) received analgesia within 20 minutes. 50% of patients received analgesia within 30 minutes (increase of 12%) and 75% of patients received analgesia within 60 minutes (7% improvement).
- It was acknowledged that whilst there had been some improvements made since the formal 2012 CEM audit, there was “still room for improvement” including the provision of additional staff training, a review of processes to ensure patients were provided with analgesia at first contact with clinical staff (during triage) and improved documentation.

Pain in Children Performance:

- Pain scoring tools, relevant to the child’s age were used in the children’s emergency department.
- 64% of patients who presented to the paediatric ED during 2011/2012 who complained of moderate or severe pain as a result of fractured elbow, forearm, wrist, ankle, tibia, fibula or femur received analgesia within 20 minutes of arrival. This placed the trust in the upper quartile (56%) when compared nationally.
- The CEM recommends that 50% of children who present to an ED in severe pain should receive analgesia within 20 minutes. The paediatric ED was placed in the upper quartile for this standard, with 67% of children receiving analgesia. However, when compared to the trusts performance of this standard in 2009, at which time the department attained this standard in 80% of eligible cases, the performance data for 2011/2012 is disappointing.
- The CEM audit data for managing Pain in Children for 2011/2012 also highlights the need for the department to review its current practices regarding the re-assessment of pain in children once they have received analgesia. In 2009, 39% of cases were re-assessed to determine the effectiveness of analgesia. This had reduced to only 12% in 2011/2012, placing the trust between the lower (8%) and median (18%) national quartile.

- We noted that there were distraction therapies for children. These included sensory equipment, bubbles and music.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- Patients in the waiting area were seen to be offered tea and coffee and patients in the EDOU were offered the full menu service which was consistent with the ward service.
- Nutritional needs and assessments were recorded within the nursing record on the electronic computer system.

Patient outcomes

- Frimley Park Hospital NHS Foundation Trust participated in 13 of the 16 national audits undertaken by the College of Emergency Medicine since 2009.
- Guidance from the NICE Head Injury Guidelines (2007) recommend that all patients who present to a trauma service having sustained a head injury, and who have a reported Glasgow Coma Scale score of 13 or less should undergo a computerised tomography (CT) scan within one hour of arrival. Between January 2011 to 17 August 2014, 38 patients who met these criteria were admitted to Frimley Park Hospital. 31 patients underwent a CT scan of their head, with the reported median time from arrival to scan being reported as under one hour.
- The Royal College of Surgeons and the British Orthopaedic Association consider that the examination of the chest is a fundamental component of the cardio-pulmonary assessment of the seriously injured patient and such an assessment should be supervised by a senior, experienced clinician. The Trauma Audit and Research Network (TARN) monitor the number of patients who undergo a chest examination having sustained a cardiothoracic injury. Between January 2011 to 17 August 2014, 300 patients were admitted to Frimley Park Hospital ED, having sustained an injury to their chest. 74.1% of patients were examined by a consultant grade clinician. This was better than the national average of 64.2%.
- The CEM recommends that the unplanned re-attendance rates within seven days for EDs should be between 1% and 5%. The national average is around 7%. The trust re-attendance rate was 2.6%

Competent staff

- Appraisals of both medical and nursing staff were undertaken and staff spoke positively about the process.
- The trust reported that 85% of staff had received an appraisal in the previous 12 months.
- 90% of senior nursing staff had attended appraisal training to help support them to carry out appraisals of junior staff.
- Each of the 16 ED consultants had received an annual appraisal and all had received 360 degree feedback as part of their appraisal process.
- We spoke with junior doctors who told us that they received regular supervision from the emergency department consultants as well as weekly teaching.
- The trust reported that all of the senior band 5 and band 6 nurses had undertaken training in immediate life support.
- Each Band 6 nurse responsible for assuming the “in-charge” responsibility in the ED had completed advanced life support training.
- 27 nurses had successfully completed the Advanced Trauma Life Support observer course and 38 nurses had completed the Trauma Immediate Life Support course.
- Two nurses had completed the European Trauma Course and nine nurses had successfully completed the Trauma Team Member course.
- Reception staff reported that they received annual training in basic life support.

Multidisciplinary working

- There were many examples of internal MDT working. We noted that the close liaison between the ED and the Care of the Elderly physician was a particularly innovative approach to help the department to manage the high number of elderly patients that attended the ED. We observed the team working within the EDOU on our second day of inspection. The team had been seen to help enhance the management of patients aged 75 years and over who had arrived into the ED having suffered a fall in the community setting. The number of patients aged 75 and over who had been discharged directly from the EDOU between July and December 2013 was approximately 70% each month. This was noted to have increased from approximately 70% to around 80% since January 2014. This meant that the number of elderly patients being admitted to a ward

setting was being reduced on a monthly basis. The team were pro-active in supporting patients to be discharged directly from the ED or EDOU by facilitating access to mobility aids as an example.

Are accident and emergency services caring?

Good

Overall, the ED provided a caring and compassionate service.

We observed staff treating patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Compassionate care

- The ED conducted a monthly survey to seek the views and feedback of 100 patients who had received care or treatment in the ED during the preceding month. Between April 2013 and March 2014, feedback from the departmental survey shows that patients rate the "Dedication and Qualification" of the medical, nursing and reception staff as being 4 out of 5 (1 being the lowest and 5 being the highest). Patients rated the standard of care as also being 4 out of 5 during the same time period.
- In 2012 CQC carried out a survey of patients who used ED services. We asked 850 people to rate their experiences of the ED services provided by Frimley Park Hospital. We received 316 completed surveys.
- The trust scored an "Average" rating for all 37 questions when compared to other NHS EDs.
- The trust performed marginally better than the England average for the Friends and Family Test. In June 2014 the trust scored 54 as compared with the England average of 53. We noted that the return rate for the trust was significantly better than the national average (42.9% vs 20.8%) In May 2014, the ED scored 52 as compared to the national average of 54 (response rate was 45.6% vs a national average of 19.1%).
- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring attitudes towards patients.
- Staff were attentive to both the child's and parents' needs at the Frimley Park Hospital
- One child we spoke with said, "The nurses and doctors have been very friendly and kind to me".
- One parent we spoke with said, "The staff have kept me informed all of the way. They seem professional and are extremely friendly".

Patient understanding and involvement

- We observed bedside handover within the EDOU; we noted that patients were engaged in the handover and were invited to ask questions and to raise any concerns as part of the handover process.

Emotional support

- The ED provided a local bereavement service which was facilitated by an ED consultant.
- Since June 2013, the ED has partnered with Farnborough Samaritans who offer support to both patients and staff each week in the main ED.

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

(for example, to feedback?)

Outstanding

The department was able to demonstrate that despite the increasing demands with increased attendances, they could cope with its routine workload as well as being in a position to actively manage surges of activity. The emergency department was redesigned in 2012; the senior ED team have considered the design, floor plan and work streams from internationally renowned trauma units, including a leading trauma centre in the United States. The results of this research and visits to those units had resulted in the ED being designed to meet the needs of the future population to which Frimley Park Foundation NHS Trust serves.

The team learned from complaints received and reviewed ways to improve both their practice and patient experience within the department.

Accident and emergency

Service planning and delivery to meet the needs of local people

- The number of patients attending Frimley Park Hospital ED had increased from 90,000 in 2007/2008 to over 105,000 attendances in 2012/2013.
- The department had a major refurbishment in 2012; the design took into consideration the future needs of the local population. The ED and Day Surgery Unit won "Best Community Building" for the South East Region (Local Authority Building Control (LBAC) Building Excellence Award) in 2013. Assessment criteria for this award included: overall project management, sensitivity to the local environment and the design of the building when considering the commercial purpose of the building.
- As part of the redevelopment of the ED, the department increased its existing capacity from 17 majors cubicles to a 26-bedded majors area which was designed with individual cubicles to enhance the privacy and dignity of patients.
- In order to manage the increasing demand on the service, additional initiatives had been proposed; at the time of the inspection, these initiatives had yet to be launched however work was under way to develop a nurse practitioner service overseen by the consultant body and a small number of advanced nurse practitioners had been identified to extend their roles to include the assessment and management of patients categorised as "majors". Majors nurse practitioner protocols were in the process of being developed such as for patients presenting with abdominal, cardiovascular, neurological and respiratory conditions.
- An audit of attendances to the Minor Injuries Unit (MIU) at Frimley Park Hospital had been carried out in 2014. 40% of attendances were identified as non-emergency cases but patients still attended the MIU. The audit revealed that patients had attempted to book an appointment with their general practitioner (GP) but an appointment was not available, resulting in the patient presenting to the ED. In addition, it was noted that a significant number of patients had been referred to the ED from a third party care provider. The findings of the audit were presented to the local Clinical Commissioning Groups in order that urgent and emergency care services across the region could be considered in order that the system became more efficient.

Access and flow

- Frimley Park Hospital was one of only a small number of NHS trusts nationally to achieve the national target of seeing 95% of patients within four hours consistently each quarter for the previous three years. Year to date figures demonstrated 95.6% of patients were seen, admitted, transferred or discharged within 4 hours of arrival. Where breaches of the four hour target occurred, both medical and nursing staff reviewed each case to determine the reasons behind the breach to help identify any areas that required improvement.
- Year to date figures showed that the median time patients could expect to first be seen for initial assessment is 14 minutes. This is in line with the CEM standard of 15 minutes.
- The CEM recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Between April 2013 and April 2014, the 95% percentile for the time people were required to wait before receiving treatment was 1 hour and 6 minutes, peaking to 1 hour and 19 minutes in March 2014. This means that 95% of people waited less than this time from first arriving in the ED to receiving treatment.
- The median amount of time people could expect to spend in the ED before being discharged, admitted or transferred between April 2013 and May 2014 was approximately three hours. This demonstrated that although patients may be required to wait marginally longer than one hour to receive treatment, the majority of patients could expect to be discharged or admitted from the department within three hours.
- Between April 2013 and August 2014 there have been no reported breaches of patients waiting for more than 12 hours in the ED once a decision to admit had been made.
- The national average for the percentage of patients who leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) was between 2% and 3% (December 2012–December 2013). Year to date, the percentage of patients who left the ED at Frimley Park Hospital before receiving treatment was 1.5%.
- Year to date, the ED has managed to ensure that 92.6% of ambulances who transport patients to the ED were kept waiting for no more than 15 minutes before patients are handed over to the care of the ED.

Accident and emergency

Meeting people's individual needs

- As part of the re-design of the ED in 2012, a specialist bariatric major's cubicle was incorporated into the into the majors area; the cubicle has increased floor space, a specialist bed designed to accommodate obese patients and integrated manual handling devices such as wall mounted hoists to help staff manage obese patients.
- Two cubicles located in the major's area had been designed so as to allow the environment to be more appropriate to those patients attending the department who are living with dementia.
- The reception area had a designated hearing loop and buzzers were available to those patients hard of hearing with a tactile way of being alerted.
- The ED had a number of dementia link nurses predominantly based in the EDOU. One dementia link nurse has developed a dementia friendly "Activity box" containing a range of reminiscence activities as well as having a range of music from various eras to help comfort and reassure patients who are admitted to EDOU.
- Although the provision of psychiatric liaison services had increased to a 24 hour/7 day service in February 2014, the funding for this service discontinued as the trust had originally utilised a proportion of their winter pressures fund to support the increase in this service. Due to the positive outcomes, the management team had submitted a business case to the executive team to consider continued funding of this service. The business case had not been ratified at the time of the inspection.
- The EDOU provides a Community In-Reach Team who is responsible for reviewing patients who present to the ED with complex needs so as to ensure that they are appropriately managed whilst in the ED.
- Representatives of the ED form part of the quorum for the Admissions Avoidance Group whose role it is to review patients who frequently re-attend the ED to ensure that patient management plans are available to staff in order that specific patients are managed in the most appropriate way. This included patients whose care was shared with external agencies such as Mental Health Providers.
- Consultants attend local acute oncology meetings so that the ED remains informed of patients who may present to the department whilst also under the care of the oncology department.
- Information was available to patients with regards to domestic violence.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). A dedicated member of staff within the ED team reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging. Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.
- Information was readily available for patients who wished to make a complaint and required support in doing so. This included contact details for the independent advocacy service SEAP (Support, Empower, Advocate, Promote) which was based in Hampshire, Surrey and Berkshire.

Are accident and emergency services well-led?

Outstanding ☆

Staff across all grades were proud of working for the service. It was evident that staff within the department worked well as a team. The staff that we spoke with were aware of the trusts values and behaviours and also of the department's local values.

Clear governance structures were in place which had been designed to enhance patient outcomes.

The NHS South West London and Surrey Trauma Network review panel commended the trust on the work that was being undertaken to develop a thoracic trauma patient pathway which had demonstrated a reduced length of stay for this patient group.

Vision and strategy for this service

- The hospital had introduced a set of three core values, which had been adopted by each of the staff members we spoke with.
- A&E had developed additional departmental values, which had been designed to:
  - Enhance patient care
  - Further improve staff morale

- Develop a competent workforce through a local programme of training and education.

Governance, risk management and quality measurement

- A robust clinical governance system was in place in the department. One consultant had been appointed as the governance lead, and regular reports were produced to demonstrate the effectiveness of the department.
- These reports provided a balanced view of the department. The consultants we spoke with were clear about the challenges the department faced. They were each committed to enhancing the patient journey and were actively involved in some form of developmental working group within the department.
- For example, one consultant was leading on research into clinical leadership, and another was working with the emergency nurse practitioners to ensure that they were suitably supervised and skilled to carry out their roles.
- There was a robust process in place for ensuring that the results of radiology investigations were followed up to ensure that any "missed abnormality" was followed up in a timely manner.
- Where the department had previously performed poorly in national audits, the ED team ensured that action plans were devised and timely re-audits were carried out to ensure improvements were made to enhance patient outcomes. Examples of re-audits outside of national programmes included Severe Septic Shock and Sepsis and Fractured Neck of Femur Audits.
- A departmental risk register was available and was under review at the time of our inspection to ensure that the content of the register was reflective of the real-time risks within the department.
- Representatives from the NHS South West London and Surrey Trauma Network carried out a review of the Trauma unit located at Frimley Park Hospital on 13 January 2014. It was noted that the review panel considered the trauma unit at Frimley Park Hospital to be a strong engager at network level and the trust continued to demonstrate organisation commitment with examples including the business case submission for a new CT scanner within the ED. The review panel identified that whilst there was a strong Mortality and Morbidity (M&M) review structure within the department, minutes of meetings did not always show how governance loops were being closed. Improvements to the format of the minutes of M&M meetings have since taken place and the trust had invested in additional administration support for the department to help enable this change.

Leadership and culture within the service

- The department was headed by a Clinical Director and Matron. Staff told us that the management team was open, approachable and provided good leadership. Staff said that this openness gave them the confidence to challenge poor practice and raise concerns. They said that they had confidence in the management team and that they felt that management would address any issues or concerns in a timely fashion. We considered that the hierarchy within the department was flat, which leant towards enabling staff of all grades to raise concerns with the management team without fear of retribution. This encouraged a "No blame" culture to flourish within the department. In addition we found that where staff had made errors or where omissions of care had occurred, staff were prepared to accept those omissions or errors and were prepared to learn from their mistakes.
- In the NHS 2013 staff survey, 11% of staff said they strongly agreed that they received feedback about changes made in response to incidents, errors, or near misses. This compares with the national average of 7% (the trust performed better than expected)
- Overall, staff told us they were proud to work for the hospital. The team appeared to be efficient, and the concept of teamwork seemed to be evident in the department.

Public and staff engagement

- In the NHS 2013 Staff Survey, 82% of staff reported that they felt satisfied with the quality of work and patient care they were able to deliver. This compared with a national average of 77%.
- The trust scored about the same as other trusts when considering whether staff felt supported by their immediate line managers.
- 41% of staff reported good communication between senior management and staff; this compared with a national average of 32%.
- 69% of staff considered that they could contribute towards improvements at work; this was rated as the same as the national average.

Accident and emergency

Innovation, improvement and sustainability

- The NHS South West London and Surrey Trauma Network review panel commended the trust on the work that was being undertaken to develop a thoracic trauma patient pathway which had demonstrated a reduced length of stay for this patient group.
- Daily ward rounds with the Care of the Elderly Physician were consistent with the recommendations of the British Geriatrics Society guidance (Silver Book) relating to the management of, and improvement of emergency care to elderly patients.
- There was clear evidence that the presence of an elderly care physician led to improved outcomes for patients who attended the hospital having sustained a fall; the department and individuals involved should be commended for their continued success in this area.
- The introduction of mannequin supported simulation training by way of the "You can't kill the mannequin" programme within the ED department to help develop staff new to the ED environment, was considered as having a positive impact on the clinical competency of staff.

Medical care (including older people's care)

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

Information about the service

At the time of our inspection Frimley Park Hospital had just over 320 beds within the medical division providing care for a wide variety of medical conditions. Both stroke thrombolysis and primary percutaneous coronary intervention was consultant led 24 hours a day, seven days a week and provided on site. In addition to the normal level of care provided on the general medical wards the hospital also hosted a medical acute dependency unit which provided Level 1 care for medical patients who required short term increased support or monitoring.

During our inspection we visited all of the medical wards and day assessment areas. We also visited patients who were being looked after by medical consultants but due to lack of capacity on the general medical wards were accommodated on surgical wards.

We spoke with a wide range of staff, including all grades of nursing staff, healthcare assistants, domestic staff, consultants, doctors, junior doctors, pharmacists, Allied Healthcare Professionals (AHPs) and porters. Due to the recent change over of junior doctors we were conscious that many of them had only worked in the trust for a few days and this was taken into account during those conversations. We spoke with patients currently undergoing treatment on the medical wards and in the day units and those close to them. We also observed care and treatment and looked at patient records, including medical notes, nursing notes, and drug charts. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall we rated medical care as outstanding. Medical care provided at Frimley Park Hospital was rated as good for safety as patients were protected from avoidable harm and abuse. Incidents were reported, learned from and in general fed back to staff. The trust was aware of areas in which it needed to improve (such as falls) and there were established work streams to improve harm free care. The department was clean and there was an active infection control and prevention team who audited practices regularly. The trust used its own early warning score (known as the Medical Emergency Team (MET) score) which again was well audited, and, as well as a Critical Care Outreach Team (CCOT), staff could call the Medical Emergency Team if they had concerns regarding a patient's condition. With the exception of one ward, all wards were well staffed and frontline staff told us they felt confident that they could increase their numbers if their acuity or dependency changed and that this would be supported by their senior managers. There was increasing consultant presence on site from 8am to 12 midnight seven days a week and the number of junior doctors on the wards out of hours had been increased in response to the increased number of medical patients within the hospital.

Medical care services at Frimley Park were rated as good in terms of delivering effective care. There was evidence of easily accessible guidelines on the trust intranet and specific audit checklists had been developed for two

conditions which have been raised nationally as a potential area in which care needs to improve. The Summary Hospital-level Mortality Indicator (SHMI) for the trust remains within expected levels and its readmission rate is better than the national average. National audits were contributed to as expected, and we were given evidence of changes made by specialities in response to their outcomes. We witnessed strong and respectful multidisciplinary team working during our inspection and this was corroborated by feedback from all disciplines spoken with. Enhancing seven-day services was demonstrated to be a priority for the medical directorate and, although this was not yet fully in place at present there was a clear and achievable business case in progress.

We rated the medical care services outstanding for being caring. This was because throughout our inspection we witnessed exemplary patient centred care being given. Wards felt calm despite some being very busy and the nursing staff were seen to be relaxed and cheerful while undertaking their work. We heard very few buzzers sounding throughout our visit, and those we did hear were answered very quickly. Interactions between staff and patients appeared natural and easy-going - communication was respectful but friendly. All relatives we spoke with praised the staff and the standard of care that their relative had received.

Medical care provided at Frimley Park Hospital was responsive to patients' needs. In common with all acute trusts, Frimley Park Hospital struggled with the management of flow through the hospital due to the significant rise in emergency attendances and subsequent admissions. Consistent with the national picture, this was largely felt in the medical division. Significant work had been undertaken to reduce the number of unnecessary admissions in terms of developing robust ambulatory pathways and providing geriatrician input to the Emergency Department (ED). Achievement of the four-hour target was seen as much as the responsibility of the medical teams as the ED and joint admission proformas had been developed to allow flex in the admission pathway when either team was particularly stretched. Equally extensive work had been undertaken to improve discharge planning from both a medical and allied health professional standpoint seven days a week. There were still ongoing issues with the number of patient moves (and those occurring out of hours), and patient outliers; both of these were escalated to the chief nurse on a weekly basis. Following a previous inspection by CQC, there was increased visibility of the work being undertaken to improve the experience of patients admitted who were living with dementia.

We rated medical care services outstanding in terms of being well-led. There was a clear vision and strategy for the service, which, despite the potential for uncertainty regarding the acquisition, was well developed and well understood throughout the department. The behaviours and actions of staff working in the division mirrored the trust values of 'Committed to Excellence, Working Together, Facing the Future' of which we saw multiple examples of during our inspection. There was evident ownership of services and patient-centred care was clearly a priority. Risks (and potential risks) were identified early and discussed openly and there was a governance structure in place that allowed formal escalation where appropriate. The trust (and therefore directorate) welcomed views and input from staff and the local community allowing for a real sense of engagement and therefore empowerment from those involved in the services to improve the quality of care being provided.

Medical care (including older people's care)

Are medical care services safe?

Good

Medical care provided at Frimley Park Hospital was rated as good for safety as patients were protected from avoidable harm and abuse. Incidents were reported, learnt from and in the large fed back to staff. The trust was aware of areas in which it needed to improve (such as falls) and there were established work streams to improve harm free care. The department was clean and there was an active infection control and prevention team who audited practices regularly. The trust used their own early warning score (known as the Medical Emergency Team (MET) score) which again was well audited, and, as well as a Critical Care Outreach Team (CCOT), staff could call the Medical Emergency Team if they had concerns regarding a patient's condition. With the exception of one ward, wards were well staffed and frontline staff told us they felt confident that they could increase their numbers if their acuity or dependency changed and that this would be supported by their senior managers. There was increasing consultant presence on site from 8am to 12 midnight seven days a week and the number of junior doctors on the wards out of hours had been increased in response to the increased number of medical patients within the hospital.

Incidents

- Staff we spoke to knew how to report incidents and told us that they were encouraged by senior colleagues to do so. There was an active drive to increase incident reporting rates, and an increase in number of incidents filed from 2012/13 to 2013/14 was seen by the directorate as a positive move in terms of improving patient safety.
- In particular there was an emphasis on increasing the number of incidents reported by medical staff (rather than just nursing and other allied health professionals) and between 2012/13 and 2013/4 there was an increase of 42% of incidents reported by this staff group.
- During 2013/14, 18 serious incidents were identified. Incident reports were discussed at a departmental clinical governance meeting which fed directly into the medical directorate meeting. A medical directorate dashboard was updated monthly and circulated to all consultants and senior nursing staff to highlight recent problems.
- The two most commonly reported incident categories in medicine during 2013/14 were pressure sores and falls, followed by drug errors.
- Events causing moderate or severe harm or death were assessed by the trust risk department. Four of 34 such incidents in the trust during 2013/14 occurred in medicine. The directorate was able to demonstrate changes as a result of the investigations into these events, such as changes to the proposed revised discharge summary to mandate reporting of key investigations following a missed abnormality on a chest x-ray.
- In addition, "Round Table" discussions were used to facilitate open discussion between clinical staff in different directorates for learning outside of formal root cause analyses, where key points from such meetings can be re-discussed.
- However when we spoke directly to frontline ward staff there was some confusion as to how themes from incidents were reported back to them and although the very serious incidents appeared to filter down to staff, this did not appear to be consistent in terms of less serious incidents and many reported not being aware of how they were meant to receive this information. (Please note, due to the recent changeover of junior medical staff (doctors) we did not ask them this question as most had only been at the trust for one day).
- The medical directorate was fully engaged with the trust Patient Safety programme, contributing three of the four trusts named patient safety clinicians. The directorate also contributed the chair of the Safe Medicines Group, which reviewed all drug errors.
- Mortality and morbidity meetings were well established in the directorate and evidently seen as a priority in terms of learning and improving patient care. All deaths were routinely reviewed by the consultant responsible for their care to firstly to ensure that the death certification was accurate, but also to identify whether the death was avoidable at all. Clinicians presented cases in a dedicated session within the departmental directorate meeting which included 10 randomly selected deaths, all cardiac arrest calls, any cases flagged by departments or the global trigger tool, and coroners inquests.
- A monthly grand round was dedicated to discussing recent cases to encourage wider participation and

greater reach of the pertinent learning points. These meetings were open to all and lunch was provided. In addition there was a quarterly mortality and morbidity bulletin which was sent to all staff.

- Cases where there was potential for cross-directorate learning were escalated to a trust wide mortality and morbidity committee that reported to the trust patient safety committee. This facilitated changes to policy requiring involvement of other departments such as their lumbar puncture procedures policy for intracranial infection.

Safety Thermometer

- The NHS Safety Thermometer is a national initiative, local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- Performance against the four possible harms (falls, pressure ulcers, VTE and catheter associated UTIs) was monitored across Medicine and Elderly Care on a monthly basis using this tool. On a quarterly basis, monitoring was undertaken through peer review to ensure the quality of data.
- Results were included on the ward performance dashboards which were presented at the monthly operational heads of nursing meeting and bi-annually by speciality to the board of directors.
- The trust year to date results for VTE risk assessment was 97% against a target of 96%. The VTE assessment was part of the trust medication chart, alongside the assessment algorithm, contraindications and doses to be used.
- As a result of the Safety Thermometer, a trust-wide work stream was being developed to assess catheter associated UTI and to reduce the number of catheters inserted. This was being led by the head of nursing for practice development & education.
- The number of falls reported by the trust increased by 11% from 2012/13 to 2013/14. 21 of these falls resulted in a significant injury to the patient (all but three of these occurred on medical wards). In addition to the detailed root cause analysis undertaken for each of these falls, a baseline audit of 100 patient falls was completed. This identified that falls risk assessments were not always being competed properly, postural blood pressure was not always being measured and that in terms of the falls resulting in a significant injury, the majority of patients had underlying confusion.
- An improvement strategy in terms of falls had been developed and was witnessed during our inspection which included resource folders for risk assessment in all clinical areas, training of "falls champions", a post-fall checklist and regular audit cycle. In additional, a further part time patient safety facilitator with a specific focus on patient falls had been funded and appointed to.
- Medicine reported eight hospital acquired pressure sores in the same period, however the rates of Grade 2 and 3 pressure ulcers have fallen by 38% and 53% in the trust over the past year and there had been no Grade 4 pressure ulcers for over two years. A trust wide audit had been initiated and Frimley Park hospital was due take part in a national research study around the benefit of air mattress use.

Cleanliness, infection control and hygiene

- The ward areas appeared clean. Although we noted that alcohol gel was not available at every ward entrance, it was present at every bedside. The infection control lead nurse confirmed that the trust policy was to ensure that gel was used by staff before and after every patient contact and thus the positioning of gel was intentional. Staff were observed to use the gel in line with this.
- A continuous cycle of hand hygiene audit reported 97% overall compliance on the medical wards, with a 100% compliance rate among medical doctors.
- The trust had had no outbreak of norovirus for four years, and had not had a PICC line infection since January 2013.
- There were seven cases of Clostridium difficile (C. diff) infection and four Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases in the medical directorate in 2013/14.
- All hospital acquired infections were root-cause analysed. For cases of C. diff infection, the clinical team and lead infection control nurse prepared independent reports which were discussed at a case-specific root-cause meeting with the medical director. Findings were jointly presented to the trust board by the infection control team and responsible consultant. Results and actions were fed back at a directorate level and via monthly medical director briefings.
- Root cause analyses for the cases of C.diff demonstrated an association with a commonly used antibiotic (co-amoxiclav) for respiratory related infections. As a direct consequence, prescribing policies were amended in a joint project with microbiology and medicine.

Medical care (including older people's care)

- An audit of patient involvement in infection prevention and control practices was undertaken between January and March 2014 involving 162 patients. This asked several basic questions around hand hygiene ('do staff assist/ ask you to clean your hands after toileting?' (Yes - 87%), 'do you see staff cleaning their hands?' (Yes - 95%), 'do you feel comfortable to ask a staff member to clean their hands?' (Yes -78%)). Two areas that the trust identified as needing to improve were regarding patients not knowing who to contact if they did not feel that the cleanliness of the hospital environment and equipment was of high enough standard (Yes-58%) and 'do you find it easy to access information on infection prevention and control at the hospital?' (Yes - 71%). These were both addressed by their inclusion in the bedside information packs recently introduced.
- The lead nurse for infection control agreed that infection control and prevention was seen as a priority for the trust and that she had good support from the senior team with whom she could speak with directly. She was able to give examples where when specific clinicians had been resistant to change, she had been given direct support by the medical director and as a result the issue was resolved. The infection control and prevention committee, chaired by the Director of Patient Safety and Infection (DPSI) was attended by a Non-Executive Director and the Chief Executive and reported directly to the Clinical Governance Committee.

Environment and equipment

- Resuscitation equipment was checked daily and well documented.
- Wards were well equipped and members of staff raised no concerns with regards to availability of equipment.
- Equipment was witnessed to be well maintained and checked in line with national recommendations.

Medicines

- The trust had an over-arching medicine management policy which was reviewed annually and included expected prescribing standards.
- There was a trust wide safer medications forum chaired by a consultant rheumatologist in conjunction with the head of patient safety where all drug related incidents were reviewed. Themes and changes in practice arising from incident reporting were shared through monthly 'Safer Medication' newsletters and via the representatives on the committee to their individual specialities.
- Nine drug errors with harm (eight with low harm and one with severe harm) were reported across Medicine and Elderly Care between July 13 and June 14.
- A trust-wide work stream on the management of opiates was initiated partly as a result of the severe harm incident in the medical directorate where a patient was prescribed and received a significant overdose of morphine. This process was captured in the safe medicines bullet points stored on the trust intranet and led to a new opiate lanyard card for staff.
- Spot check audits to assess compliance with the antibiotic prescribing bundle were conducted on alternate months in all medical subspecialties by the medical directorate infection lead reporting directly to the hospital infection control board. Additional audits were conducted by pharmacy every four months.
- Pilot schemes to increase safety had been evaluated, such as the ward checklist in respiratory medicine. Antibiotic prescribing compliance increased from 80% to more than 94%. Further use demonstrated sustained levels in excess of 90% across multiple audits. Following a period of revision, the checklist was planned for re-launch across medicine.
- All medicines dispensed on discharge have the relevant patient information leaflet included. In addition there was a patient helpline in place allowing patients the opportunity to call in with any questions they may have regarding their medication once they have been discharged.
- Medication charts were reviewed twice daily by a pharmacist on the acute medical unit.
- Controlled Drugs (CD) were handled appropriately and stored securely. A spot check undertaken on several of the wards demonstrated compliance with relevant legislation.

Records

- Individualised care plans were used throughout the trust. The trust also uses a variety of care pathways and care bundles to assess and monitor the nursing care provided.
- Nursing records looked at during our inspection were noted to be comprehensive and well completed. Medical notes were found to be legible and well filed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place which was based on the Department of Health model consent policy. All

consent forms are included in the policy. The policy includes the process for consent, documentation, responsibilities for the consent process, consent training, use of information leaflets to describe the risks and benefits which are developed on a standard template. The policy also includes consent for children, advanced decisions, Lasting Power of Attorneys guidance, Mental Capacity Guidance and checklist and the use of Independent Mental Capacity Advocates (IMCAs) where appropriate. The policy outlines guidance on provisions for patients whose first language is not English including the use of an interpreter's list and language line.

- There was a consent committee which meets quarterly to review policy, new guidance, review audit results and review any concerns raised through incidents, complaints & claims.
- Safeguarding adults, Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) was included on corporate induction of all clinical staff and is included in mandatory patient safety training which staff attend annually. Training on the mental capacity act and DoLS is also provided to Foundation Year One's as part of their educational program.
- We found during our inspection that assessments were undertaken appropriately on the medical wards.

Safeguarding

- Face to Level 1 safeguarding adults training was undertaken by groups of staff who were not clinical but had contact with patients e.g. receptionists and domestics. Level 2 Safeguarding Adults training had been provided for nursing staff of band 6 and above. Level 3 Safeguarding Adults Training had been provided by an external company for senior ward sisters.
- The trust had a safeguarding committee where alerts and referrals were reviewed
- The trust had a dedicated adult safeguarding lead nurse; the lead clinician was a consultant endocrinologist from medicine
- Level one and two safeguarding training was part of the mandatory training undertaken by all medical staff on joining the trust.

Mandatory training

- The trust had a program of mandatory training for all staff, and there were regular 'Skills Blitz' days held for targeted training in key areas.
- All doctors undertook mandatory training as part of their induction and as of July 2014 97% of doctors within the medical directorate had completed this.

Management of the deteriorating patient

- The trust has their own adaptation of the National Early Warning Score known as the 'Medical Emergency Team' (MET) score. We discussed the use of this with a member of the resuscitation team. Their system had been audited extensively to compare the effectiveness of identifying the deteriorating patient with the more recognised national scoring system. The trust wide scoring system includes measurement of urine output unlike NEWS which is felt by the trust to improve its sensitivity. They also felt that their 'trigger points' were at least as sensitive as the ones used as part of the NEWS.
- The MET team was called where there was concern over a patient's condition and consisted of the on call day team, the resus team and critical care outreach team (during working hours), ITU registrar and a porter. The emphasis was on early identification of patients who were becoming more unwell and providing increased support to ward staff in these cases.
- Since the introduction of this in 2000, the trust reported that the percentage of hospital admissions resulting in death halved from 2.5% to 1.25% in 2012, and the rate of cardiac arrests fell from 0.25% to 0.08% of admissions. 57 inpatient cardiac arrests occurred on the medical wards during 2013, with 19% surviving to discharge and remaining alive at six months.
- The resuscitation team had recently undertaken an extensive audit into this tool involving over 400 sets of patient records. Key elements looked at included whether the score was calculated appropriately and whether appropriate escalation was initiated. It found that in 25% of cases recording could have been improved which led to further training sessions for ward based staff.
- In order to assist the doctors covering the wards out of hours there was a database which lists all patients who needed a review. Patients were triaged according to urgency of review (red/amber/green). This also means that it was clear which grade of doctor should be undertaking the review.
- The trust had recently introduced an overnight warning system known as "night owls" for patients who required

review out of hours. A picture of an owl is placed next to the name of the patient on the ward whiteboard, allowing for easy identification by the day team that this patient should be seen first on the daytime ward round.

- The medical division had a Medical Acute Dependency Unit (MADU), which had recently relocated from the respiratory ward to be closer to the critical care department. This had eight beds and was used to look after patients who required up to Level 1 and 2 (which is discussed in the Critical Care section of the report) care (largely patients requiring non-invasive ventilation). There was a formal twice daily consultant ward round (led by the respiratory consultant of the week) and an intensive care consultant visited the ward daily. In addition the critical care outreach team undertook a board round in the morning, to identify if there are any patients who might need increased care (or who could be stepped down). 40% of the nursing staff working on the unit had undertaken an acute care course, to improve their knowledge in looking after acutely unwell patients.

Initial assessment and treatment

- Patients could be admitted to the medical wards either via their GP or the Emergency Department. The vast majority of patients would be admitted to the Medical Assessment Unit (MAU) rather than direct to a speciality ward.
- GP referrals were received directly by the bed manager who makes a decision (depending on how unwell the patient was) to either the ED or the MAU. It was acknowledged that currently the ED (with resus beds) was more appropriate if the patient is very unwell, therefore if a patient arrived into MAU from a GP who needed immediate treatment they would be diverted to ED. Equally there was flexibility if the reverse occurred.
- The medical assessment unit had 12 beds and two assessment rooms where nurses undertook the initial assessment of patients (including basic investigations such as an ECG and bloods). The expectation was that this would occur within 15 minutes and there were protocols for them to follow for specific conditions / presenting complaints, such as chest pain, headache and shortness of breath. Once this was completed the junior doctor reviewed the patients. Nursing staff escalated any patient who had not been seen by a doctor within four hours.

Nursing staffing

- In line with the national drive to improve the nursing ratios for wards within hospitals, the trust had invested significantly in nursing staff.
- The establishment for medical wards had been reviewed in June 2014, and staffing ratios increased to a minimum of 1:8 during the day and 1:10 at night. We witnessed during our inspection and were told by nursing staff that the wards were well staffed and they would often actually have above their establishment depending on the acuity and dependency of their patients.
- The exception of this was the respiratory ward. This had recently been reconfigured (they had an area of higher dependency which had now been downgraded to mean that it had a larger bed base of lower acuity patients). The number of staff on duty did not allow for the 1:8 ratio, representing closer to 1:10. Overnight it was as low as 1:13. We were informed that the senior team were aware of this (and when questioned this was corroborated) and that this was only a temporary situation as new nursing staff were due to start in September.
- Expected and actual staffing numbers were clearly displayed on all medical wards. In terms of ensuring staffing levels were safe on a day to day basis, compliance with the expected ratios was assessed and fed back daily to the senior team.
- Senior nurses told us that they felt supported by senior managers in terms of staffing their wards, and told us of initiatives such payment of additional overtime in August to encourage trust staff to take on vacant shifts, thus reducing the reliance on agency staff.
- Each ward was assessed against three standards (minimum 2 trained each shift, total number of staff compliance and trained compliance) as well as compliance with ratios. The expectation from the trust was that they are compliant with these ratios 90% of the time. Compliance against the standards were reported on a monthly basis to the senior management team.
- Agency staff new to the trust undergo a documented structured local induction at the start of their shift. This included specific training concerning their MET score.

Medical care (including older people's care)

Medical staffing

- There was a concerted effort within the medical division to move towards seven day services, and alongside this to roll out the "consultant of the week model", which was currently operating in respiratory.
- Currently there were ward rounds seven days a week on the acute medical unit and all patients were seen within 12 hours of their admissions in line with best practice standards. There was an acute medical consultant on the unit from 8am to 8pm (the cover is split between two consultants, the first from 8am to 4pm and the second from 12pm to 8pm). There was a third consultant on call to coincide with the late afternoon and early evening medical admission surge to ensure timely, senior and safe review of patients (and is on call from 4pm to 10pm).
- On the speciality wards, as mentioned above there was a drive to have seven day a week consultant ward rounds but in practice this is not yet in place on all wards.
- 90% of the junior doctor posts were filled by the deanery. The remaining 10% were filled with Trust Grades (at SHO level) and the trust reported at the time of our inspection that they had no vacancies within the junior doctor rota.
- In acknowledgement of the increased workload at night time (in part due to the increased number of medical patients admitted to the trust), additional junior doctors had been placed on night shift, which means there were currently five medical doctors overnight working with a senior nurse practitioner. At the weekend there were 12 junior doctors working for the directorate (this has recently been increased to acknowledge the extra Sunday consultant presence on the medical wards).
- There was a consultant led hospital night handover (commenced only recently) at 8pm which involves the day acute on-call team, night practitioners, as well as the registrar for the intensive care unit and surgical teams.
- A second handover occurs just for the medical division at 9.30pm for the day team to handover to the night team. There was a standardised checklist indicating what should be discussed, all unstable patients were highlighted and handed over formally.
- There were several different computer systems in place for handover. The acute take used one called MEDEX, whilst the wards use ADT (or 'real time').
- The importance of safe handover was highlighted and explained as part of the foundation doctor's induction programme.

Major incident awareness and training

- The trust had established an emergency planning steering group to provide assurance to the Board that plans established were updated regularly. These plans had been developed in conjunction with the local health economy.
- As well as having regular training in place to ensure that key staff are aware of their roles & responsibilities, the trust undertook an annual physical exercise. Staff on the acute medical unit were able to demonstrate their understanding of this.

Are medical care services effective?

Good

Medical care services at Frimley Park were rated as good in terms of delivering effective care. There was evidence of easily accessible guidelines on the trust intranet and specific audit checklists had been developed for two conditions which have been raised nationally as a potential area in which care needs to improve. The Summary Hospital- level Mortality Indicator (SHMI) for the trust remains within expected levels and their readmission rate is below the national average. National audit were contributed to as expected and we were given evidence of changes made by specialities in response to their outcomes. We witnessed strong and respectful multidisciplinary team working during our inspection and this was corroborated by feedback from all disciplines spoken with. Enhancing seven day services was demonstrated to be a priority for the medical directorate and, although this was not yet fully in place at present there was a clear and achievable business case in progress.

Evidence-based care and treatment

- The trusts intranet was relatively easy to navigate and guidelines could be accessed quickly and intuitively. All medical specialities had guidelines regarding the most common presentations and although some of these were beyond the date of review, there had been no change to the nationally available (i.e. NICE) guidance and standards since the trust guidelines had been written.

- There were no condition specific clerking proformas except for patients admitted with a stroke or for primary percutaneous angiography, however there were single page checklists for sepsis and acute kidney injury that were inserted into notes to be used as both a prompt and an audit tool for these conditions.

Pain relief

- The trust had a dedicated Pain Service led by a Nurse Consultant for Pain who was available to provide advice for ward patients during normal working hours (9-5, Monday to Friday). Regular audits of pain relief were undertaken.
- Comprehensive analgesia guidelines for medicine and surgery were easily available on the trust intranet.

Nutrition and hydration

- Wards used a coloured tray and cup scheme to indicate those patients who need additional help at meal times. In addition wards had a protected meal time to ensure that patients were encouraged to eat undisturbed from non-urgent care.
- An admission risk assessment booklet is completed by a qualified nurse. This includes a nutritional screen assessment tool to identify patients at risk of poor nutrition, dehydration and swallowing difficulties. It also indicated expected actions to be taken following the nutrition assessment scoring and weight recording. We saw on our inspection that these had been appropriately completed.
- Patients who were identified as high risk were directly referred to the dietetics team and patients who were identified as medium risk were re-assessed within three days. If there was no identified improvement patients were referred to the dietetics team who were present in the hospital Monday to Friday 9-5pm.
- Out of hours nurses undertook bedside swallow screening; otherwise there was a speech and language team available.
- Menus were available for those requiring consideration for religious needs. Special menus for patients with allergies were also available.

Patient outcomes

- The trust actively monitors its SHMI data, in particular regarding the differences between their weekend and weekday mortality (and between specialities). This triggered further investigation by the relevant speciality which led to improvements in coding practices. No significant preventable themes were identified although it was acknowledged that care can always be improved and lessons learnt. Outlier SHMI values have since normalised suggesting the checking process was valid. The medical directorate SHMI is currently 97.
- The emergency spell readmission rate for medicine was 12.6%, compared to a national figure of 13.8%. The 2014 annual re-admission audit performed jointly with local CCGs identified no avoidable re-admissions (among 71 cases assessed, 42% of which were medical).
- The trust contributed to the Myocardial Ischaemia National Audit Project (MINAP) and reported a door to balloon time under 90 minutes for over 95% of patients (compared to 92% nationally). The 60 minute figure (not yet nationally benchmarked), is 87%, set against a locally agreed target of 50%. 93.8% of patients were discharged on all of the secondary prevention medication compared with 89.8% nationally.
- According to the Sentinel Stroke National Audit Project (SSNAP), the trust achieved a 'C' Grade (range A (Best) to E (worst). It is acknowledged nationally that the criteria for the grading is very stringent – at present there are very few trusts that have achieved Grade 'B', and no trust has yet been awarded an 'A' grade. Based on 2013/14 trust data, 49% of strokes underwent CT scanning within an hour which is similar to national figures. 98% of all strokes had a scan within 12 hours compared to 85% nationally. The median thrombolysis time was 56 minutes (compared to 58 minutes nationally). 71% of patients have a swallowing screen within 4 hours (compared to 57% nationally). 93% see a specialist Stroke Consultant within 24 hours, and 93% were cared for on a dedicated Stroke Unit (compared to national figures of 75% and 84% respectively). Recently the median time to thrombolysis lengthened (compared to Q3 2013/14) and in response to this a dedicated stroke nurse now attends the Emergency Department Stroke calls 24-hours a day in order to try and improve the 60-minute thrombolysis target.
- COPD exacerbations comprised at least 5% of all acute medical admissions to the trust. Based on quarterly Quality Observatory data (as indexed by Surrey admissions to the trust), Frimley Park hospital had one of the lowest mortality rates for COPD (3-4% in 2013/14) in the South of England, the majority of which are approximately double this figure.
- The most unwell COPD patients commonly require non-invasive ventilation, which is administered on a

dedicated Medical Acute Dependency Unit (MADU) with staff trained in its delivery. Since October 2013 the MADU has been run by a dedicated respiratory consultant providing two ward rounds per day. Working closely with the nursing staff, the number of patient-NIV days per month had fallen from 48.5 days to 29.9 days (or 0.8 days per patient, down to 0.4 days per patient); despite a similar proportion of respiratory single organ failure admissions (65%), suggesting timely and efficient use of this resource.

- The medical directorate also participated in the British Thoracic Society (BTS) audit cycle, which has led to new clinical guidelines, prophylactic antibiotic policies, and a discharge care bundle Administered by the respiratory nurse specialist, the bundle now acts as the agreed single point of communication between multiple geographical community teams and addresses key areas of the NICE COPD Quality Statement. Provisional data submitted to the Royal College of Physicians National COPD Audit showed that referral rate for pulmonary rehabilitation for example, rose from 5% to 25% of admissions when the bundle was being used with one of the community teams.

Competent staff

- The trust held regular 'Skills Blitz' days for targeted training in key areas – which change according to current identified training needs. These were open for all staff to attend.
- The trust had a large number of Clinical Nurse Specialists (CNS) who supported specific specialities including respiratory, cardiology, epilepsy, gastroenterology, haematology, diabetes and ophthalmology. We met with a large number of them during a focus group to discuss their input into the medical directorate. Approximately 50% of them had completed their prescribing training and others commented that they had been supported by the trust to undergo their training. They spoke very positively regarding the contribution they were able to make to their speciality citing supportive senior colleagues as instrumental to this.
- 88% of nurses in medicine had a completed appraisal by their due date. The same figure was 92% for consultant staff.

Multidisciplinary working

- We observed multiple episodes of respectful and professional teamwork between staff of a complete range of seniorities and specialities (including nursing and allied health professionals).
- Respiratory medicine held a monthly MDT with the community respiratory providers to discuss difficult patients, such as those with a high symptom load or frequently admitted patients. This was also attended by a palliative care consultant to facilitate timely discussion about advanced care planning and transition to palliative care. The MDT can feed management plans to the local ambulance service and Emergency Department. It also linked in with the motor neurone disease MDT hosted by palliative care. It had improved communication about these patients across organisations and led to on-going collaborative work around pathways for inpatient support during feeding tube insertion.
- The Cardiac team had developed a heart failure shared care model in collaboration with the CCGs. Pathways for identification and specialist referral had been agreed in accordance with NICE recommendations to facilitate timely diagnosis, treatment and specialist review. An MDT with all three local CCG teams was held twice per month, and also involved a palliative care consultant. The MDT team tried to support and supervise care closer to home, and had developed heart failure rehabilitation in the community, and were training nurse and pharmacist prescribers to run medication titration clinics.
- The neurology service provided joint clinics within other specialities (obstetrics, paediatrics, pain service) to better reach those populations
- Most wards told us that they had their own physiotherapists, but that due to a shortage of occupational therapists (OT) they had to 'share' them with other wards. Some OTs covered up to four wards, and we saw that they prioritised their presence on the stroke and elderly care wards.

Seven-day services

- There was a strong drive to develop consultant led seven day services within the medical directorate (and the trust). The business case outlining the required investment by the board had been accepted and recruitment was ongoing.

Medical care (including older people's care)

- Already, stroke services were provided 24/7 using telemedicine for thrombolysis and there was daily consultant review of all stroke patients.
- In addition, cardiology provided 24/7 primary percutaneous coronary intervention and there was a daily consultant ward round for the Coronary Care Unit and for step-down cardiology.
- Respiratory also provided seven day cover for the Medical Acute Dependency Unit (MADU) with a daily consultant ward round as well as covering the respiratory zone and cystic fibrosis ward.
- The acute medical unit had a resident consultant from 08.00-22.00 covering the medical take and current inpatients. The trust had recently introduced an additional consultant on Sundays to increase the number of patients receiving a review over the weekend.
- The proposed seven day consultant care for subspecialties such as gastroenterology and Endocrine/ Elderly Care is due by September 2014. Most of the required consultant recruitment had been completed; however there were still vacancies for some of the elderly care posts.
- There was a significantly reduced physiotherapy service available at the weekend with one physiotherapist covering all medical patients including the stroke unit, respiratory and general mobility needs. However on the stroke unit, the stroke coordinator was trained to mobilise any patients who might be suitable for discharge.
- A full radiology service was provided on site for a reduced number of hours at the weekend (although there is an on call service 24/7) and the pharmacy was open until 1pm on both Saturday and Sundays.

Are medical care services caring?

Outstanding ☆

We rated the medical care services outstanding for caring. This was because a caring culture was felt to be fully embedded throughout the medical directorate and throughout our inspection we witnessed exemplary patient centred care being given. Wards felt calm despite some being very busy and the nursing staff were seen to be relaxed and cheerful whilst undertaking their work, taking the time to consider individual patients needs. We heard very few buzzers sounding throughout our visit, and those we did were answered very quickly. Interactions between staff and patients appeared natural and easy-going - communication was respectful but friendly. All relatives we spoke with praised the staff and the standard of care that their relative had received.

Compassionate care

- During our inspection we witnessed staff behaving in caring manner towards their patients. Staff were cheerful and spoke kindly towards both relatives and those they were caring for.
- We saw multiple examples of relaxed conversations occurring between staff and patients, with both parties using first names to address each other. We also watched interactions between staff and relatives. It was clear that the staff knew the relatives well and we saw them take time to explain and update them on their loved ones condition.
- Patients were seen to be relaxed and comfortable and the ward was calm despite on occasion being quite busy.
- Curtains were drawn appropriately when staff were delivering care and we witnessed patients receiving support when transferring to the bathroom.
- During meal times we witnessed ward clerks supporting patients with their food.
- Patient buzzers were answered promptly and we found that staff spoke quietly when discussing personal matters to ensure confidentiality was maintained.
- In June 2014 the trust scored above the England average (73) in the Friends and Family test achieving 79. The response rate was also slightly above the national average at 41%. The medical division scored 73 overall for 2013-14.
- The trust scored in line with other trusts for the CQC inpatient survey 2013.

Understanding and involvement of patients and those close to them

- The trust had recently introduced patient information packs which we saw were provided at every bedside. This included information about the hospital and what they should expect in terms of their care whilst an inpatient. It also outlined who to contact if they had any concerns about their treatment whilst on the wards.
- Each bay had a small white board at its entrance which detailed the name of the nurse responsible for the care delivered. In addition the surname of the consultant looking after each patient was displayed here.

- The nurse in charge for the ward wore a clearly visible red badge so that both patients and relatives could easily identify them.
- Patients we spoke with told us that they had been kept informed regarding the care that they were receiving and that both the medical and nursing staff were approachable when they had had any concerns.
- We also spoke to patients about the support that they had received from allied health professionals such as physiotherapists and occupational therapists. They reported that they had been encouraged to learn to do the exercises when on their own and that the way that these had been explained to them had empowered them to feel more in control of their condition.

Emotional support

- We witnessed staff providing emotional support to patients during our inspection. When patients were not able to communicate (due to living with severe dementia) we saw that staff continued to talk through their actions and watch for non-verbal communication in order to try to assess what the patient might prefer.
- One relative told us that she felt her mother's care had been 'second to none' and that she had 'absolutely no complaints'
- Another patient reported that the nurses were 'very attentive' and that they had been provided with everything that they needed.

Are medical care services responsive?

Outstanding ☆

Medical care provided at Frimley Park Hospital was responsive to patient's needs. In common with all acute trusts Frimley Park hospital struggled with the management of flow through the hospital due to the significant rise in emergency attendances and subsequent admissions. Consistent with the national picture this was largely felt in the medical division. Significant work had been undertaken to reduce the number of unnecessary admissions in terms of developing robust ambulatory pathways and providing geriatrician input to the Emergency Department (ED). Achievement of the four hour target was seen as much as the responsibility of the medical teams as the ED and joint admission proformas had been developed to allow flex in the admission pathway when either team was particularly stretched. Equally extensive work had been undertaken to improve discharge planning from both a medical and allied health professional standpoint seven days a week. There was still ongoing issues with the number of patient moves (and those occurring out of hours), and patient outliers, both of these were escalated to the chief nurse on a weekly basis. Following a previous inspection by the CQC there was increased visibility of the work being undertaken to improve the experience of patients admitted who were living with dementia.

Service planning and delivery to meet the needs of local people

- 19 ambulatory care pathways had been developed (which were all easily available on the trust intranet) in order to try to reduce unnecessary admissions and readmissions. The observed percentage of admissions was lower than expected in relation to asthma and chest pain and within range for most others. Following the observation that they had higher than expected admission rates for patients diagnosed with pulmonary emboli they had updated the relevant pathway.
- A recent pilot scheme had been introduced to increase consultant geriatrician input to the Emergency Department (Observation Unit). This aimed to both enhance service provision for elderly patients as well as identify patients with non-medical needs that could be managed without admission. This service had run on weekdays only so far, but the difference in the rate of non-medical admissions when present compared with when not was 9% versus 25%
- There was a relatively large Nepalese community in the local area. In response to this the trust developed a team of 19 Nepalese interpreters who were trained as Level 4 translators at Southampton University. In addition, commonly required information such as food menus had been translated into Nepalese.
- So that patients undergoing treatment for cancer could receive follow up consultations closer to their homes, the medical directorate had developed links with the Royal Marsden and the Royal Surrey Hospitals.
- At the entrance to wards there were clear signs stating 'Night-time starts at 10pm' in addition to the prompt 'TLC' – Think, Lights, Cut noise. Ear plugs and eye masks were available to aid patients sleeping.
- Although in terms of bed space the wards were well organised and equipment well stored, they lacked any

communal space such as day rooms. This was acknowledged by ward staff and meant that initiatives such as the 'Music Box' (explained below) have to be held in the main section of the ward.

Access and flow

- The trust acknowledged that it continued to struggle with the management of flow through the hospital due to a significant rise in emergency attendances and subsequent admissions. Consistent with the national picture this was largely felt in the medical division.
- The medical division had worked with the Emergency department to improve the trusts 4 hour target (that all patients should be seen, assessed and either treated or discharged within four hours of arrival into the Emergency Department). A joint admitting proforma had been developed so that when either the ED or medical division were under pressure patients needing admission could be clerked by one department only rather than both as per usual. Medical consultants could therefore review patients directly in the department where the emergency department doctors would present patients directly to them.
- However, bed occupancy was frequently above the recommended 85% despite extra bed capacity being opened during periods of particular pressure.
- In addition, at the time of our inspection there were 33 so called medical outliers (these are patients who are under a medical consultant however are housed on a non-medical ward). We spoke with many of these patients and none expressed concern over their treatment whilst on the surgical wards. Nursing staff did not report any concerns with looking after medical patients and we reviewed ten sets of their notes and saw that all were being seen regularly by the medical doctors and that in all cases these reviews were undertaken in the morning. In addition, a 'medical outlier' ward round was undertaken at the weekends by a senior nurse meaning that they were all seen by a senior health professional seven days a week.
- In addition to the 'Buddy' system (where all non-medical wards have a designated 'Buddy' ward) all doctors, ward managers and senior nursing staff within the medical division receive a morning email (before 8am) listing all medical outliers in the trust that day confirming which team is responsible for them. It also indicates how many patients are awaiting bed allocation in the ED so that teams are aware of the number of patients waiting to come into hospital. Nursing staff on the outlier wards stated this system worked well and that they did not have any concerns regarding the ownership of patients and which team they should call if they had concerns.
- One of the medical wards (30 beds) was undergoing refurbishment at the time of our inspection and therefore closed. The trust anticipated that once this was re-opened the number of outliers would significantly reduce.
- Although it was trust policy not to transfer patients between wards out of hours (after 10pm) due to bed pressures this still did occur. In the month of July (which the trust stated was historically their busiest month in terms of admissions) around 50 transfers occurred out of hours.
- In order to try and improve patient flow the trust had instigated several mechanisms. Daily consultant or registrar led multidisciplinary departmental (MDT) board rounds occurred Monday to Friday and doctors were encouraged to prioritise their ward rounds to see the most unwell first and then potential discharges second rather than in traditional bed order.
- At the weekend there was a 'HIT' team, consisting of a doctor and nurse who review all potential weekend discharges as identified by the teams on the Friday.
- The Frimley Outreach Rehabilitation Team (FORT) had been operational since the end of 2013, providing home-based rehabilitation to patients who were medically fit for discharge. The aim was to support medical (or other) patients whilst community provider services were arranged and prevent re-admission due to non-medical reasons. Comparable services also existed in stroke medicine (Early Stroke Discharge Service). The trust told us that length of stay data had improved since this service had been instigated and that they are now undertaking a formal user evaluation and functional outcome data.
- The Frimley System Urgent Care Board CCG, met every 4 to 6 weeks. This group addressed issues relating to out of hours care provision for both medicine and other specialities and was responsible for the distribution of the 2013/14 additional Winter Pressures money of approximately £1.3 million. Amongst the interventions was increased Emergency Department staffing and ancillary/administration support.

- Additional nursing home beds were estimated to have saved 470 bed days during a 3-month pilot period. This was a joint pilot with the Surrey and Hampshire Social Services again in response to the additional winter pressures monies.
- Local general practitioners and the trust Emergency Department clinicians had contact numbers for multiple medical specialities for rapid advice and guidance, including acute medicine, diabetes, respiratory, cardiology and elderly care. A "readmissions" phone was also carried by one of the medical Sisters and the night nurse practitioner.
- Rapid access clinics existed in respiratory, cardiology, and neurology (general and first fit clinics), with other sub-specialities providing dedicated urgent appointments in other clinics.
- The rapid access lung (cancer) clinic was typically staffed by at least two consultants, a trainee doctor and specialist nurse. The capacity is effectively unlimited and flexes according to demand; patients can access the clinic easily throughout their diagnostic pathway for results. It is standard policy for two-week rule patients receive a CT scan prior to clinic (following a standard letter sent to patient and/or GP explaining the test and requirement for renal function assessment). Many would have also been reviewed at the lung MDT and the next investigation pre-planned.
- There were two separate meetings for patients whose discharge had been significantly delayed both of which were held weekly. The first (on a Monday) discussed all patients who been delayed up to ten days and consisted of the ward manager, lead discharge nurse, patient flow manager, social worker and occupational therapist. Each ward was given a specific time slot to come and discuss their patients. A second meeting was held for those delayed over 20 days with a similar range of staff but also by the director of nursing (occasionally referred to as Chief Nurse). Although this was a trust wide initiative, the vast majority of these patients were within the medical division.

Meeting people's individual needs

- The standard of care for patients living with dementia was identified as an area for improvement at the last CQC inspection (October 2013). Although there were already several initiatives in place at that time, these have been supplemented and built upon by the dementia steering group developed by the elderly medicine team in line with the National Dementia Strategy.
- Both the 'This is me' and 'Butterfly' scheme was used in the trust both of which were witnessed being utilised to good effect during our inspection.
- Dementia training (level 0) was included in the corporate induction programme for all new staff, and level 1 training included in the annual patient safety updates for all registered and unregistered nurses.
- The dementia nurse specialist provided monthly one hour dementia training sessions (level 1) for non-clinical staff and 75 staff had completed the dementia module with the University of Sterling. A further 25 staff have enrolled with the University of Surrey to undertake a similar course.
- The trust had designated 'Dementia Champions' all of whom undertook a three month course in dementia. This was not limited to clinical staff and several portering and catering staff had become dementia champions.
- In order to improve the patient experience on the wards, the trust had invested in a music box which held a singing session on a weekly basis. This was witnessed during our inspection when 12 patients attended. It was well facilitated by an occupational therapist, matron and health care assistants. There was also a 'D Caff' Café (held twice a month), a joint venture between the Alzheimer's society and the dementia nurse specialist to educate and support relatives and carers of people living with dementia.
- There was a trust Learning Disability (LD) liaison nurse who reviewed patients who had LD following admission. The trust encouraged the use of care 'passports' to ensure that staff had as much information and background about the individuals during their stay. Carers input and feedback was encouraged and used to improve services.
- Wards had improved their signage to increase visibility of basic services such as toilets. Coloured boards to help orientation with the day and date were placed prominently in the elderly care wards.
- The trust had a dedicated practitioner to perform targeted dementia screening assessments in patients over 75 which had contributed to the trust achieving 100% of patients over 75 screened for dementia within

72 hours of admission. The practitioner (a band 4 post) was funded by the national dementia CQIN also supported the dementia training outlined above and linked patients with additional support if required.
- The trust had a library of Patient information leaflets to inform patients about their treatment and options in a wide range of procedures. The leaflets all followed a hospital design and included both risk and benefits. They were available locally or through the trust intranet.

Learning from complaints and concerns

- Complaints in the medical directorate fell by 46% in the last year (from 179 to 97) and were all read by the Clinical Director for medicine.
- Complainants were supported by the patient advice and liaison service (PALS) who collated the responses provided by relevant medical, nursing or other staff described in the complaint. The PALS team would arrange a meeting with family if requested, and a recording of any meeting could be provided for the complainant's further reflection and consideration.
- Examples of responsiveness and change could be demonstrated by the directorate. One example was the response to a complaint in cardiology around end of life care. In this ward area and others, the palliative care team now attend the morning MDT board rounds. One of the cardiology consultants was also setting up a bereavement clinic for patient's families who have concerns or questions regarding the death of loved on, particularly if the death was sudden or unexpected.

Are medical care services well-led?

Outstanding ☆

We rated medical care services outstanding in terms of being well led. There was a clear vision and strategy for the service, which despite the potential for uncertainty regarding the acquisition, was well developed and well understood throughout the department. The behaviours and actions of staff working in the division mirrored the trust values of 'Committed to Excellence, Working Together, Facing the Future' of which we saw multiple examples of during our inspection. There was evident ownership of services and patient centred care was clearly a priority. Risks (and potential risks) where identified early and discussed openly and there was a governance structure in place that allowed formal escalation where appropriate.

The trust (and therefore directorate) welcomed views and input from staff and the local community allowing for a real sense of engagement and therefore empowerment from those involved in the services to improve the quality of care being provided.

Vision and strategy for this service

- The overarching vision for the medical directorate was articulated to us as providing consultant led (and delivered) high quality care seven days a week using effective multidisciplinary working to achieve this aim.
- There was a clear (and partially fulfilled) strategy in place to facilitate this which had been developed in conjunction with the division and accepted by the senior board.
- The upcoming acquisition of Heatherwood and Wexham Park NHS Foundation Trust had had an obvious impact on the leaders within the medical division as increasingly their time would be spent on the other site developing the services there.
- That said, there was clear acknowledgement that the high quality care vision at Frimley Park could not be allowed to falter, and there was clear depth and breadth in the leadership team to mitigate this risk.
- Frontline staff were all aware of the acquisition and felt that it had been well communicated with them. Local leadership (at ward level) was unlikely to change significantly, and this provided reassurance to the staff that the overall desire to provide a consistently high performing service was not seen as any less of a priority to both the medical division and the senior team.

Governance, risk management and quality measurement

- Monthly directorate meetings, chaired by the clinical director were held within the division. Separate clinical governance meetings occurred monthly and fed into this meeting. In addition performance of individual specialities was discussed (based on the medical directorate dashboard).
- Information regarding outliers and bed moves (acknowledged as a significant risk to patient experience) and nursing staffing was discussed daily by heads of nursing. This was then escalated weekly to the performance meeting and discussed monthly at the medical directorate meeting. It was presented to the board on a six monthly basis.
- The division held its own risk register, which was discussed monthly at the clinical governance meeting.

- The relationship between the directorate and the senior team was strong, and staff members at all levels reported that there was an open door policy, and if they had concerns regarding the service they were providing they would feel comfortable speaking directly to them. Several staff members were able to give examples of when they had done this and how their comments had been well received. This empowered the staff further to speak up when they felt care could be improved.

Leadership of service

- The medical directorate (the largest of the Frimley Park Hospital directorates) operated with a single clinical director and a deputy. Given the planned acquisition the deputy CD has been given increasing responsibilities in terms of leading the directorate. From July 2014 the role of deputy CD has been rotated between speciality consultants on a 6-monthly basis to develop the more "junior" members of the consultant body to and to encourage better understanding of the issues at directorate level.
- An associate director, together with the heads of nursing and matrons, support the clinical director, and help to develop strategy and monitor performance.
- Each of the sub-specialities had named lead clinician to facilitate the rapid escalation or dissemination of information and independently make appropriate decisions on the day to day working of their individual services. Further support to the CD for junior staff comes from a consultant in the directorate who has a specific role in junior staff, rotas and from the clinical tutor and his deputy who have training and pastoral support responsibilities for trainees.
- There are three heads of nursing related to medicine (Medicine and Elderly Care, Cardiology and Respiratory/ Paediatrics/Patient Flow). All report to the associate director of medicine and are professionally accountable to the Director of Nursing (occasionally referred to as Chief Nurse).
- Matrons in clinical areas report to the heads of nursing, who provide leadership and professional accountability. Ward sisters (or managers) were supervisory on most of the medical wards two shifts out of five, which is slightly below the national recommendation of 50% of the time.
- Staff spoke positively about the leadership on the wards and during our inspection we were impressed by the local leadership we witnessed on all of the medical wards.
- The junior doctors we spoke with (which again given the timing was limited) stated that they felt well supported and that their colleagues who had just rotated through the division handed over that the jobs were 'busy' but that 'you will be supported'.

Culture within the service

- We were told ahead of our inspection that a guiding principle of the trust and directorate was for clinician engagement and leadership in all clinical areas and projects and this was highly evident. There was a clear sense of ownership of services and that providing good quality care and patient experience was everyone's responsibility.
- Staff took obvious pride in working for Frimley, evidenced not only by the behaviours witnessed during our inspection but also by the most recent staff survey in which 85% of trust staff stated that they would recommend Frimley Park Hospital.
- The level of staff sickness absence in medicine is low at 2.1% (target 2.9%). Staff turnover in medicine is currently 12%.
- The clinical tutor monitors the progress of trainees in regular meeting with educational supervisors.

Public and staff engagement

- The trust has an active public engagement strategy. It holds constituency meetings to update and involve local patients and stakeholders quarterly. Clinicians are encouraged to help host these events which are frequently attended by over 100 members of the local community.
- The trust also has over 16 000 Foundation Trust members and actively seeks their views on various topics regarding the hospital such as changes to the trust visiting times.
- In view of the upcoming acquisition and the potential for concern or confusion over the future provision of local services, the trust has tried to proactively engage further with the community to reassure them of what changes (or not) will result from the trusts combining.
- In terms of the medical division specifically, the trust engages with a variety of support groups such as the Motor Neuron Disease Association who attend the joint monthly Frimley Park and Phyllis Tuckwell Hospice multidisciplinary meeting.

- In addition, the trust works with the local Cystic Fibrosis (CF) charity and CF Trust. The CF Unit build and several subsequent renovations have occurred as a direct consequence of such collaboration.
- Nursing students we spoke with told us that they had been made to feel welcome and part of the trust

Innovation, improvement and sustainability

- It was clear from the number of staff members we spoke to that the development and training of staff was seen as a high priority by the trust and this resulted in staff feeling invested in and valued.
- Multiple staff members told us that they had come up with suggestions for improving a service and that 'provided you could give a good case for it' that they would be supported by their seniors to implement changes. There was a clear sense of engagement and empowerment of staff (even the most junior ward staff) as a result.
- Frimley Park hospital is regarded as the best in the Kent, Surrey and Sussex region for training in terms of the feedback given by junior doctors. Contributing to this was the directorate education provided though weekly Grand Round and "Top-20" teaching sessions. In addition, weekly educational meetings occurred in sub-specialities (respiratory, cardiology, elderly care and diabetes/endocrinology).
- The Gastroenterology and Hepatology Department won an NHS England Innovation Award for their work relating to healthcare delivery via telemedicine to prison populations in response to the high rates of chronic viral hepatitis infection. This is being developed further via a project with NHS England and the Ministry of Justice, in partnership with the University of Surrey. Their work has led to recognition of Frimley as a centre for prescription of new high cost anti-viral drugs within the NHS England specialist funding structure and will receive referrals from a regional population catchment. Members of the team contribute to the UK Advisory Boards for Hepatitis C and National Hepatitis B Guidelines.

Surgery

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

Information about the service

Frimley Park Hospital NHS Foundation Trust provides both elective and emergency surgery to the population of North East Hampshire and West Surrey, and parts of East Berkshire with a wider catchment for specialist services.

The surgical division consist of a number of speciality services including; surgical assessment unit, day surgery and in-patient treatment and care for people undergoing breast, orthopaedics, ear, nose and throat (ENT), urology, gynaecology, and ophthalmology, vascular and general surgery. There is provision for pre-operative assessment, anaesthesia, 18 operating theatres, three minor operation rooms and a designated recovery unit. The number of surgical beds available is 211, 17 of which are used for surgical short stay.

We visited the day surgery unit, operating theatres and main recovery. We also visited the pre-operative department 'POD' and orthopaedic, general surgery, vascular and urology wards. During our inspection we spoke with 10 patients and 25 staff from a range of various surgical related roles. We reviewed treatment and care records for 15 patients and made observations of staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resource.

Summary of findings

Overall we rated surgical services outstanding. Patients who required surgical interventions were managed safely and effectively in accordance with recommended professional guidance. Procedures were in place to continuously monitor patient safety. There were sufficient numbers of skilled and knowledgeable staff to safely meet the needs of patients. Knowledge of the learning from training was demonstrated through the staffs' attention to safe practices and adherence to hospital policies. The environment was suitably clean and the equipment needed to deliver care was readily available. Arrangements were in place to access prescribed medicines, including pain relief, and medicines were managed safely.

Patients' needs had been assessed and reviewed. Records were completed for each stage of care and treatment given, and the consent was sought from patients or their advocate. Arrangements were in place for emergency care. Staff had access to consultant-led care for advice and guidance and there was access to diagnostic services and operating theatres outside of normal working hours. Surgeons, anaesthetists and clinical staff followed professional guidance, local policies and procedures. The multi-disciplinary team shared responsibility for delivering people's treatment across all seven days. Surgical outcomes were monitored and information was communicated through the governance arrangements to the trust board.

Surgery

Patients described their experiences positively, such as, “I have had excellent care on every ward. I have been told all about my progress”, “staff asked what I wanted to be called and offered help and support, and they can’t do enough.” Patients told us that staff respected their privacy and dignity. The majority of staff were observed to be kind, caring and attentive to people’s needs. We did hear confidential information being discussed as part of the nurse handover between shifts, which some patients may not have liked.

Patients told us they had been given information by doctors and nurses. Information was accessible in a range of formats. The nutritional needs of patients were being assessed and people’s religious, cultural and medical dietary needs were met. Although there were some bed capacity issues at times, which resulted in surgical patients not being placed on the most appropriate wards, there were arrangements in place to ensure that the right surgical expertise led on their care, and clinical decisions were made responsibly. People who had particular physical or mental health needs were supported by staff who had been trained in these areas, including care needs associated with dementia. Although very few complaints had arisen directly from people’s experiences of using the surgical services, there were arrangements in place to respond to complaints in accordance with a local policy.

The surgical services were led by a highly committed, enthusiastic team of staff, each of whom shared a passion and responsibility for delivering a first class service. Staff described leadership as “excellent” and “visible”. Staff understood the ethos of the service and the corporate values, and demonstrated a commitment to delivering a quality service to the patients. Governance arrangements enabled the effective identification of risks, monitoring of such risks and the review of progress on action plans. Regular detailed reporting enabled senior managers and representatives of the trust’s board to be aware of performance and where improvements had positively impacted on service delivery. The views of the public and stakeholders had been actively sought. The surgical division was engaged in a number of research trials and had contributed to the body of knowledge in surgical specialties. Trainee doctors considered the trust to be an excellent place to gain experience in surgery and reported effective supportive networks.

Surgery

Are surgery services safe?

Good

Procedures were in place to report, investigate and learn from any adverse events. Continuous monitoring of essential indicators of patient safety was taking place. The results from such monitoring were being reviewed as part of the quality and governance processes.

There were sufficient numbers of skilled and knowledgeable staff in place to safely meet the needs of patients. Arrangements to backfill gaps caused by sickness absence, holidays, training or when vacancies arose were managed effectively. Staff had received training in safety related subjects, including; safeguarding vulnerable people, mental capacity, and resuscitation as well as infection control. Knowledge of the learning from this training was demonstrated through the staffs' attention to safe practices and adherence to hospital policies.

The environment in which patients received their care was found to be suitably clean and equipment needed to deliver care was readily available. Arrangements were in place to ensure patients had access to prescribed medicines and the management of these was carried out in accordance with safe practices and legal requirements.

Clinical staff used various means of assessing and reviewing the needs of their patients to ensure they received safe interventions. Records were completed for each stage of treatment and care provided and the consent was sought from patients or their advocate before investigations, treatment and care was carried out. The medical team were responsive in times of emergency and staff always had access to consultant-led care for advice and guidance.

At times of high activity there were procedures to follow in order that patient safety and wellbeing was not compromised.

Incidents

- Incident reporting and learning was embedded in the practices of staff across surgical wards and theatres. Staff we spoke with were confident in their explanations of the reporting mechanisms for any adverse event, near miss or accident using the trust wide electronic recording system. We saw that such events were reported as part of routine practice and investigated as part of the safety processes. The head of nursing and clinical matron attended the clinical risk management committee where incidents were reviewed and discussed. Critical incidents were also discussed at directorate clinical governance forums, which were said to meet six times per year. We saw information from incident reviews was shared through team meetings.
- The surgical directorate participated in the Morbidity and Mortality (M&M) Group. This group brought together all those with an interest in improving practice around morbidity and mortality outcomes, in order to ensure multi-professional learning was shared across specialties, and to monitor performance against these goals. The M&M Group provided assurance to the board that all unexpected deaths were reviewed and specialty mortality trends examined. We saw detailed information, which demonstrated a full review process for orthopaedic mortalities, including areas for improvement.

Safety thermometer

- Surgical areas participated in the monitoring of patient care in line with the NHS Safety Thermometer. Information had been collected in respect to patient falls, catheters and urinary tract infections, as well as the incidence of pressure sores. Results of the safety thermometer were displayed on ward notice boards, examples of which included:

1. Surgical Ward: F7 - Urology/Vascular: Days since last fall = 324, Days since last pressure ulcer = 43, Days since last Medication error = 0
2. Surgical Ward: F4 - Fractured Neck of Femur: Days since last fall = 774, Days since last pressure ulcer = 26, Days since last Medication error = 601
3. Surgical Ward: F8 - General Surgery: Days since last fall = 14, Days since last pressure ulcer = 14, Days since last Medication error = 0

- Clinical staff followed NICE guidance in regard to falls prevention, fractured neck of femur, pressure area care and VTE.

Cleanliness, infection control and hygiene

- We made observations in surgical ward areas, pre-assessment rooms and operating theatres and recovery. We found the standard of cleanliness to be good and domestic staff were observed following guidance in regard to required cleaning standards,

practices and frequency of cleaning. All the patients who spoke with us told us they were satisfied with the level of cleanliness and commented favourably on the frequency of cleaning and hard work of domestic staff. Comments included, "I am very satisfied."

- Staff had access to an up to date policy in regard to Methicillin-resistant Staphylococcus Aureus (MRSA) which we saw outlined the key practices related to minimising risks to vulnerable people. The Department of Health (2010) requires NHS Trusts to screen all relevant elective and emergency admissions and to monitor screening compliance, with the exception of some specified types of admission. Compliance rates for screening both elective surgical and emergency admissions were high with a rate achieved of 95% and above for the period of January 2014 to the end of June 2014. We saw evidence of MRSA screening in the nursing records we reviewed.
- Each ward area visited displayed positive figures indicating the number of days since there had been any Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.diff) infections as follows:

1. Surgical Ward: F7 - Urology/Vascular: Days since MRSA = 2,775, Days since C. Diff = 926
2. Surgical Ward: F4 - Fractured Neck of Femur: Days since MRSA = 1,333, Days since C. Diff = 142
3. Surgical Ward: F8 - General Surgery: Days since MRSA = 415, Days since C. Diff = 519
4. Surgical Ward: F5 – Trauma: Days since MRSA = 701, Days since C. Diff = 860

- Clinical staff followed NICE guidance in regard to falls prevention, fractured neck of femur, pressure area care and VTE.
- Surgical staff informed us there were lead nurses for infection control in each area. Staff were required to attend infection prevention and control training as a mandatory subject and monitoring of this was undertaken by the learning and development team.
- We observed staff working in surgical areas to be bare below the elbow. There was access to decontaminate hand gels on entry to all areas and also at the point of care. We saw staff using hand washing and drying facilities between the delivery of care activities, as well as hand gels. Personal protective equipment, such as gloves and aprons was readily available and used by staff in all surgical areas we visited.
- We observed staff in all surgical areas visited following best practice infection control principles in relation to management of waste, including sharps items, contaminated waste and laundry. Equipment used for patient care such as commodes were checked and found to be clean and ready for use. Cleaning of items used by patients was carried out in accordance with the decontamination policy we reviewed. Staff confirmed some items of patient use equipment such as hoist slings were single patient use, which minimised potential for cross contamination.
- Isolation signage was in use to indicate to visitors and staff the need to follow various precautions.
- Within the theatre department we saw staff were adhering to NICE guidance related to infection control and surgical site infection prevention.

Environment and equipment

- We saw, and staff confirmed in their discussion with us, sufficient availability of equipment, including electrical devices and single use disposable items. We checked electrical items on each surgical ward and did not identify any visible signs to indicate the items had been subject to portable appliance testing. We discussed this with staff and they indicated there were regular checks undertaken by the responsible department; however, they were surprised that no stickers were attached to items to indicate the tests had been completed or the next required test date.
- Resuscitation equipment was readily available and checked daily. Emergency equipment was accessible and included relevant drugs, oxygen and medical devices. Where omissions of checks on equipment had been identified by senior nursing staff, this was discussed at unit meetings and minuted accordingly.
- Staff working in the operating theatre department reported having sufficient theatre instrumentation to enable them to undertake their operating lists. There were effective arrangements in place for processing instrumentation on site. We concluded the theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.

Medicines

- Surgical ward staff confirmed with us they had access to regular pharmacy advice and input with regard to medicines management. The pharmacists visited the

wards on week days and checked prescription records and raised any queries with respective doctors. They also undertook checks on antibiotic prescribing and compliance with agreed protocols.

- Storage arrangements were seen to be in place for the different types of medicines, including items which required refrigeration. We saw temperature checks had been carried out on these fridges, thus ensuring correct, safe storage. Suitable disposal arrangements were in place for expired or no longer required medicines.
- We checked the arrangements for the management of controlled drugs (CD), including registers in theatre. Records for the ordering, receipt and regular checks were in place. Administration records included the name of the patient, date and time of administration, dose and signatures of staff who gave the drug and the witness to this. Patient medication records corresponded with CD doses administered. Separate CD registers were kept for CD's belonging to and brought in by patients. There were processes to be followed regarding disposal of unused or expired CD's.
- Medicines charts checked as part of the patient records review indicated a thorough process around prescribing and administration, with allergies recorded and discrepancies noted, such as reasons for medicine not having been given. Night staff were seen conducting a medicines round on one of the surgical wards visited. We saw staff wore a red plastic tabard indicating they should not be interrupted during the activity. We concluded the process was conducted safely, with checks made of prescription, medicines and the patient receiving them. Patients were supported to have their medicine and the nursing staff made sure each medicine had been taken as prescribed before moving on to the next patient.
- Staff told us about the arrangements for obtaining medicines patients needed to take home, known as TTO's. Medicines were prescribed as usual by doctors and these were obtained from pharmacy during working hours. Wards had a small supply of simple medicines such as pain relief which could be given out subject to appropriate checks out of hours. There was also access to on call pharmacist for items which were not available in ward TTO stock cupboards.
- Medicines errors, including errors resulting in harm were reported as part of the patient safety performance monitoring dashboard. Across the orthopaedic wards we saw year-to-date low scores for medication errors of 27, of which three had resulted in harm to the patient. In general surgery wards including the surgical assessment unit and short stay surgery there had been 34 reported medicines errors, of which none resulted in harm.
- Pharmacy staff undertook audits of compliance with the antibiotic prescribing protocols. We saw the results for the audit conducted in June 2014 and saw this indicated general compliance as having increased and overall antimicrobial usage decreasing across the hospital. In surgery the use of antibiotics was slightly less for the quarter, despite a peak usage seen in June.

Records

- We examined 13 patients' nursing and medical records on the surgical wards we visited. All patients had been subject to an initial assessment, which identified personal demographics, medical and surgical history and such matters concerning allergies and current medication. The assessment included an explanation as to the reason for admission, be this for an elective surgical procedure or as an emergency admission. In the latter case presenting concerns and symptoms had been outlined, along with initial assessment and investigative tests.
- Assessment booklets were used for documenting all relevant information and we saw the booklet also included standard risk assessments. Risks assessments covered areas including, moving and handling, risks of skin damage over pressure areas using a recognised tool called the 'Waterlow' risk assessment. There were risk assessment around nutritional needs and the use of bed rails for safety reasons. One set of nursing assessment records had not been completed although it was clear the patient had specific needs which would have arisen from risk assessments. For example, they had been referred to the tissue viability and vascular nurse specialist in regard to a wound but their risk assessment around skin integrity, moving and handling or nutrition had not been completed. We noted in regard to moving and handling, two separate areas for reporting the assessment of patient status; however, the resulting assessment was not always consistent in how the risk was viewed or in the action to be taken to minimise such risk. For example, in the case of one patient falls assessment it was seen the 'liability to falls' trigger was indicated. However there no falls plan in place to manage this. In another case there was no trigger for an intervention although the person walked

with a stick. Despite this we saw the staff had identified three concerns and were taking appropriate action to minimise the identified risks. Discussion with the lead nurse for the area of patient falls agreed the current documentation was confusing.

- Personalised care needs had been identified for each patient, in some cases using care pathways specific to the type of surgery. For example in the pre-assessment unit nursing staff commenced the care pathway for patients undergoing fractured neck of femur, total knee replacement and spinal care. The first stage of the patient journey included any required referral to the anaesthetist or other speciality service such as cardiology. Investigations were highlighted as were risks and information pertaining to the discharge arrangements. These care plans were used as the patient progressed through the actual admission, surgery and post-operative phases. Where patient had individual needs requiring nurse help or support from allied health professionals, including physiotherapists or dieticians, this was indicated in care records.
- The name of the nurse responsible for the patients' admission assessment had been recorded in the majority of cases. We saw progress notes recorded and inclusion of detailed information from physiotherapy, podiatrist, dietician and speech and language therapy (SALT) personnel where relevant.
- Medical and nursing notes were found to be clear enough to read and understand the information. The use of poorly photocopied versions of some documentation rather than original copies to record information in made it harder to read details clearly. Surgical records included information about the patient theatre episode from anaesthetic through operative procedure and for the initial post- operative recovery and subsequent progress period up to discharge.
- Where patients had gone to theatre for a surgical procedure we saw arrangements in place to ensure checks were made prior to during and after surgical procedures in accordance with best practice principles. This included consistent completion of the World Health Organisation (WHO) surgical safety checklist in operating theatres. WHO checks were also carried out on patient who had interventional radiology and endoscopic procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to a consent policy based on the Department of Health's guidance. The surgical team undertook checks using the World Health organisation (WHO) safety procedures to ensure consent had been obtained prior to the performance of a surgical procedure.
- Within the pre-assessment unit we asked staff about patient consent for forthcoming surgery. Staff explained how patient consent was obtained by the consultant. They informed us also and provided examples of consent information given to patients, for example, patient information for consent in relation to a general anaesthetic or a Trans Urethral Resection of Prostate (TURP). Evidence of patients having been given information prior to surgery was seen in records we reviewed. Signed consent forms were present in the records of patients who had undergone surgery. We saw medical staff providing information and securing consent from a patient who was going to theatre for surgery during our visit. Patients who spoke with us recalled being given sufficient information to enable them to make informed decisions about their treatment and care.
- We spoke with staff about patients who may not have been able to fully understand information about their treatment and care needs as a result of their mental capacity. In regard to pre-assessment staff told us where a person attended with their carer they discussed consent but advised of the need to bring their next of kin with them or nominated advocate in order to ensure information was understood and consent could be obtained. Any pre-operative tests were postponed until arrangements were in place for consent to be validated.
- Staff who undertook site management had received training in regard to mental capacity and Deprivation of Liberty Safeguards (DoLS) so they could support staff. The DoLS are part of the Mental Capacity Act 2005, (MCA). They aim to make sure people in hospitals are looked after in a way that does not inappropriately restrict their freedom. Most staff who we spoke with about mental capacity and DoLS had an understanding of these areas and were aware of their responsibilities in meeting the needs of patients. We saw evidence in care records of the need to have formal diagnosis of capacity

and where best interest meetings were required arrangements had commenced to ensure this was arranged. There was access to guidance and policies for staff to refer to in regard to MCA and DoLS.

Safeguarding

- Staff training in relation to safeguarding vulnerable people was provided at different levels. For example, band six and seven staff had been trained to level two. We saw from training figures 100% compliance across surgical areas for level one training, which included non-clinical staff who provide face to face contact with people, such as domestic staff and receptionists. Compliance above 89% was seen for level two training, which applied to nursing staff above a band six level. Medical staff received safeguarding training as part of their induction.
- Staff had access to guidance and information within the trusts safeguarding policy as well as having links to the local authority safeguarding team. Photographs of the safeguarding leads and their contact numbers were displayed in some ward areas. The Trust Safeguarding Committee reviewed alerts and referrals. Nursing staff knew who the nominated safeguarding leads were and could describe the actions they would take if they were concerned about a person. Examples of recent safeguarding concerns were described to us and the information provided assurance of staffs' knowledge and awareness of their responsibilities towards vulnerable patients.
- Patient and public had access to an informative safeguarding web page on the hospital internet. This provided definitions along with what to look out for and links to relevant local authorities.

Mandatory training

- Surgical staff reported having access to a range of mandatory training subjects, which included for example; infection control, manual handling, safeguarding, health and safety, equality and diversity. Training statistics were produced each quarter and these were presented at the Nursing and Midwifery Board. Medical and consultant mandatory training was monitored via the Post Graduate Education Centre. The surgical directorate had an action plan in respect to areas of mandatory training completion, with targets above 85%. We saw from this action was required in subject areas of blood transfusion assessment, mentor updates, and dementia to improve internal compliance. Training attendance information was communicated via the clinical governance reports and we saw for example in regard to orthopaedics in excess of 90% of staff had been trained in patient safety.

Management of deteriorating patients

- Patients receiving post-surgical care were nursed in accordance with the National Institute for Health and Care Excellence (NICE) guidance; "Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital." We noted in our review of patient records that staff used an early warning score system to identify and respond to the deteriorating patient. This involved assessing the condition of patients, such as their heart rate, respirations and level of consciousness. Medical staff were summoned as part of the 'Medical Emergency Team' (MET) in the event of a score indicating a potential or actual concern, enabling the correct interventions to be put in place to manage the patient's condition safely. Responses to such emergency requests were recorded as part of the safety dimensions on the department dashboards.
- Clinical staff were seen to be following the five steps to safer surgery, which included; pre-brief before commencing operating lists, sign-in of the patient, time out, sign out and de-brief. Surgical specialities checked compliance with this process and we saw information, which reported high levels of compliance within the clinical governance reports. Staff reported de-briefs as being a valued part of the process, although what was discussed was not necessarily recorded formally.
- Access to theatre in emergency cases was arranged via the emergency CEPOD theatre up to 22:00 hours and thereafter via on-call staff.

Nursing staffing

- Ward areas within the surgical directorate complete a monthly 'tracker' record, which gave an overview of the number of staff in post and staff availability to roster, taking into account absences such as holidays, sickness or maternity leave.
- Staffing levels were being monitored continuously and local standards of compliance were reported monthly for the staff ratios on each shift.
- Staffing levels of both qualified nurses and healthcare workers for each part of the 24 hour period were displayed on all surgical wards we visited. We saw these staffing levels were accurately reflected in our

observations and the arrangements indicated sufficient staff to meet the needs of patients at the time. Staff responded promptly to call bells and undertook their nursing duties in an unhurried manner.

- Staffing arrangements in operating theatres included cover for the emergency CEPOD theatre and one obstetric theatre running at the same time. There was also an on-call team which meant three theatres could be running at once out of hours. General staffing facilitated theatre lists between the hours of 08:00 and 13:00 followed by a break and then 14:00 to 19:00. Bank staff were used in theatre as required but there was no use of agency. Turnover rates in theatres was said to be 14% and there was a vacancy rate of 13 trained nurses and four untrained staff. Vacancies were attributed to various factors, such as national shortage of anaesthetic support staff and higher pay rates being offered by other providers. There were incentives in place for filling vacant positions and retaining new recruits. The recovery unit had multi-skilled and flexible staff who also provided staffing cover for the four ITU beds in the unit and at busy times, worked in the Critical Care Unit when needed.
- Information was provided to us in regard to the workforce arrangements which highlighted in particular vacancies in the area of orthopaedics. We saw there were whole time equivalent (WTE) vacancies of 10.46 trained staff and 6.81 untrained vacancies as of June 2014 across the three orthopaedic wards. Recruitment was in hand and 3 WTE trained personnel were due to commence their roles. Vacancies in other surgical ward areas were noted to be much less of an issue, with only 2.2 WTE vacant trained posts and 3.48 untrained.
- Agency staff were not used in operating theatres but were used on occasion, as were regular bank staff to support surgical services where shortfalls were identified in staffing levels. A process was in place to check the suitability of agency staff prior to arranging their work placement. This included for example; checking before an agency worker commenced employment that the agency had fully completed the Agency Worker Placement Checklist, which was available from the intranet. The agency was expected to confirm six pre-employment checks had been carried out on each occasion workers were supplied, except where there was a repeat booking.
- Handovers on ward areas took place between the change of shifts early morning and late evening. We joined the ward handover between night and day staff on an orthopaedic ward and found the staff provided detailed information which enabled them to take over the required care and support of each patient.
- Agency staff new to the trust undergo a documented structured local induction at the start of their shift. This included specific training concerning their MET score.

Medical staffing

- Vacancy levels were low in the medical establishment and there was forward planning of rotas managed by the speciality clinicians. Escalation of gaps was made to the associate director or on-call manager. Attempts were made to back fill from internal staff before approaching locum staff.
- Surgical services were overseen and led by consultants over each 24 hour period. Arrangements were in place to ensure the surgical directorate had access to and support of consultant surgeons and anaesthetists during both normal and out of hours. Information on staff availability was provided to ward and theatre areas, thus ensuring that relevant support could be accessed. .

Major incident awareness and training

- The trust had in place business continuity action cards to support the emergency planning and preparedness policy.
- The trust had an escalation policy in place designed to enable effective management of fluctuations in demand and capacity so that it could manage associated clinical risk within acceptable limits. During high levels of alert the head of nursing for surgery had a responsibility to 'rationalise' the elective surgery list with the patient flow managers.

Are surgery services effective?

Good

The surgery services were effective. Surgeons, anaesthetists and clinical staff followed professional guidance, local policies and procedures where appropriate and undertook monitoring of compliance with these, including audit of the impact of such measures.

People reported that surgical staff managed their pain effectively and we found there were a range of supportive measures in place to ensure people's needs were

addressed. This included having access to a pain team and a lead anaesthetist for pain services. The nutritional needs of patients were being assessed and people were supported to eat and drink a balanced diet in accordance with their specific needs. Religious, cultural and medical diets could be catered for and there was access to dietetic services for guidance and support.

Surgical outcomes were monitored and results contributed to a range of external comparative reports indicating the service was performing well in a number of areas. Information was also communicated through the governance arrangements to the trust board so they had oversight of the surgical division's performance.

Staff had a range of suitable skills, assessed through competency checks to enable them to undertake their duties effectively. The multi-disciplinary team shared responsibility for delivering people's treatment and care needs enabling a seven day service to be provided.

Evidence-based care and treatment

- Surgical specialities managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons (RCS). For example there were 11 clinical guidelines and interventional procedures which the orthopaedic services complied with. This included for example, shoulder resurfacing arthroplasty and the management of hip fracture in adults. The ENT directorate followed NICE protocols in relation to glue ear, suction adenoidectomy and undertook on-going audits of compliance in a number of procedures.
- As part of the South East Coast Strategic Clinical Networks the trust participated in monitoring lower limb amputation and provided information to the 'Diabetic Foot Care Summary'. We saw a retrospective audit related to amputation in diabetic patients had resulted in the availability of a diabetic 'hot foot' pathway enabling GP's and community nurses to obtain advice and rapid referral of high risk people.
- Local audit activity included checking staff compliance with various procedural protocols, such as WHO safety checks and infection control. The ophthalmic department were in the process of undertaking an audit related to intraocular lens implants.

Pain relief

- Patients who attended pre-operative assessment clinics had information about their current and post-surgical pain relief concerns and needs discussed and recorded. Information was used to inform the need for referral to the anaesthetist for additional discussion and/or the pain team. Patients were also provided with an information leaflet 'Pain relief for adults', a copy of which we reviewed. We saw this contained detailed guidance around for example, the importance of good pain relief, reducing pain, modes of pain relief and side effects.
- Staff working on surgical wards had access to the pain team if required via a bleep in addition to consultant and medical staff being available to review analgesia. Out of hours on call advice and support was available from the consultant anaesthetist. We saw staff received a newsletter titled 'Pain Matters' which provided information about changes in analgesic medicines as well as pain link nurse meetings.
- Patients had a range of options for managing surgical pain including analgesia via different routes such as oral, injection and patient controlled analgesic pump. Nursing staff working on the ward which cared for patients with fractured neck of femur reported being able to carry out Facia Iliac blocks for pain relief.
- We asked patients if they had experienced any pain and if so if nursing staff responded promptly with medicines to relieve this pain. All patients who had experienced pain at some point in time reported receiving pain relief very promptly. We heard nursing staff making patient enquires as to their level of comfort and any pain being experienced whilst on surgical ward areas. Nursing staff also handed over information about the patient status regarding pain as part of the shift changeover. This meant nursing staff were informed of any potential issues and could address patient needs in a timely way.
- Our review of patient care records indicated nursing staff assessed patients for pain at regular intervals, scoring the level of pain as expressed by the patient. A pain pathway was also used by nursing staff to manage individuals who required additional intervention and support for their pain.
- We reviewed the information provided to us which related to a snapshot pain audit that had been carried out in February 2014. We saw from this that 92% of the respondents were satisfied or very satisfied with their post-operative pain management and none experienced very severe pain.

Surgery

Nutrition and hydration.

- Nutritional assessments were identified in each patient care record we reviewed. In the majority of instances this assessment had been completed and identified where supportive measures were required. For example, we saw where supplementary nutritional foods were required or where a person required monitoring of their food intake. The involvement of the dietician was noted where relevant and we checked to see if any interventional measures were being addressed by nursing staff. For example, one person was receiving nutritional feed via a tube and this had been prescribed and was given in accordance with this. Other people needed help with dietary intake and a yellow or red tray system was in place to ensure needs were addressed by staff. Patients with a red tray required more support to eat their food and food may have needed to be cut up or pureed. People needing prompting with their food, but were more able had a yellow tray. Protected meal times were in place on surgical wards, enabling staff to help patients with minimal interruptions.
- The trust had a rotational menu, of which we were able to view for week two. The menu contained information about nut allergies, fish bones and special dietary needs, be these cultural, religious needs based or medical related. Vegetarian options were available at all meal times and there was a choice of foods at each meal time, with healthy options clearly indicated.
- We saw patients had access to fluids at regular intervals unless they were restricted, in which case this was highlighted above the bed area and in care notes. Water jugs were provided and replenished during the day. Patients who had their fluid needs restricted or managed with other interventions, such as via an intravenous line were monitored and their input and output had been recorded on the relevant record.
- We observed breakfast being served on one of the surgical wards and saw the domestic staff had responsibility for giving out meals. Before providing each patient with a tray they provided hand gel to each person, and assisted those who needed help to use this. Staff were noted to be very polite and caring in their manner towards patients. Clinical staff had responsibility for assisting people to eat and drink. In most instances this help was provided in a timely manner with due consideration and respect. In one case we noted the breakfast was placed on the bed table of a person who had bed rails in place. The tray was left there for ten minutes before the patient could get the attention of the healthcare support worker, even though they were in the immediate patient area. The staff member eventually helped the patient but was seen to open the cereal packet using a pair of scissors taken from the pocket of their uniform. This observation was shared with the matron who advised they would address the concern accordingly.
- Patient who spoke with us described their experience of the food, quality, amount and choice available. One person explained how they had gone off food but "not because of the food", adding, "The dietician came to see me and I was offered nutritious drinks but I didn't want these." All other comments received were favourable such as; "Nice food, good choice and nice cereal and porridge", "food was good" and "food, yes I like it. I have enough to eat."

Patient outcomes

- National reporting as part of the Summary Hospital-level Mortality Indicator (SHMI) for the period January 2013 to December 2013 indicated outcomes for surgical patients were in the main within expected ranges and lower than expected in general surgery.
- Hospital standardised mortality ratios (HSMR) is a measure used to assess the ratio of the actual number of in-hospital deaths in a region or hospital to the number that would have been expected based on the types of patients a region or hospital treats, among the 72 diagnosis groups accounting for about 80% of inpatient mortality. The surgical directorate reported HSMR figures for the period February 2013 to January 2014, which did not identify any concerns above the control limit.
- In 2012-13 the hospital was an outlier in relation to SHMI for orthopaedics as compared to benchmarked peers. Evidence demonstrated that in 2013 the team reviewed their processes around mortality and morbidity meetings, introduced a consultant lead for orthogeriatrics and developed an integrated trauma service between orthopaedics, anaesthetics and orthogeriatrics. These steps resulted in the non-elective SHMI reducing from 129 in August 2013 to 86 in June 2014.
- There were good arrangements in place to ensure surgical outliers had their treatment and care overseen by the appropriate specialty expertise. We observed the multi-disciplinary team (MDT) meeting which took place

each morning as part of the handover between shifts. Within this meeting surgical outliers admitted during the previous 24 hours were discussed in respect of 'ownership' and future treatment plans.

- The trust was accredited as a regional vascular centre with state of the art facilities which included three interventional radiology suites and a dedicated operating theatre. Patient outcomes for two surgical vascular procedures; elective repair of abdominal aortic aneurysm (AAA) and carotid endarterectomy were seen to be reported as part of the National Vascular Registry by seven named consultants working at the trust. In each case we noted the surgical outcome for respective consultants was within the expected range for their level of activity. Detailed audits of both procedures were viewed by the inspectors as part of the corroboration of this.
- The National Bowel Cancer Audit annual report for 2013 included submission and analysis of data presented by the trust. The trust uses the enhanced recovery programme for patients having surgery. We were provided with information, which indicated the average LOS for major colorectal cancer was 4-5 days compared to the national average of 8-9 days. The full organisational information pertaining to the National Emergency Laparotomy Audit (NELA) was not available at the time of the inspection, although data was being collected. The report was anticipated to be available in 2015.
- The orthopaedic directorate reported to the board in the quality and performance report for April 2014 that they were achieving a 95% compliance level year to date with regard to patients with a fractured neck of femur getting to theatre within 36 hours.
- Day surgery rates reported to the trust board in April 2014 indicated 85% achievement against a target of 80%. Urology services reported consistent monthly numbers for day case activity and a year to date figure of day case surgery at 86.8%. Day case activity for ENT was reported to be 71%.
- There were arrangements in place which reflected the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. This included handover of information between consultants and medical staff, involvement of the multi-disciplinary team and decision making around treatment and interventions. This included the need to access operating theatres or diagnostics. The trust also participated in a 'Trauma network' with another hospital and patients admitted with various traumatic problems were managed with combined input and decisions by speciality consultants as appropriate.
- A named consultant had been appointed for overseeing the treatment pathway for patients with fractured neck of femur. In addition a named anaesthetist provided the lead for optimising the treatment and care of these patients. Length of Stay (LOS) for elective patients was reported to be up in April but remained within target, with a year to date as of the end of April 2014 stated as 2.72 days. Non-elective LOS was the lowest since October 2013 but was still over target at 4.38 as of the end of April 2014. Examples of emergency LOS included ENT patients of 1.56 days and elective surgery LOS of 1.02 days in April 2014. Emergency urology patients with a LOS at 3.37, whilst elective LOS was 2.24 days in the same period.
- Readmission rates within 30 days varied across the period of April 2013 to the end of March 2014, with a rate of 11% or 12% and an overall year to date of 11%, with a target of 10%.

Competent staff

- We spoke to nursing staff about the range of competencies required for their roles. Some staff had extended skills such as those required to perform Facia Iliac blocks. Relevant staff were required to have a sound knowledge of the anatomy related to the technique, as well as principles and practices of the procedure. Staff were expected to observe the procedure carried out in practice and then be supervised followed by observations in order to be assessed as competent to undertake this pain relief procedure. We saw there were procedural guidelines for staff to follow.
- We were informed by nursing staff the night staff and stroke team co-ordinator had all been trained to undertake speech and language assessments for patients experiencing problems with swallowing.
- Patients using the surgical areas had access to clinical nurse specialists. For example, we saw there were specialist nurses for vascular, urology, Macmillan and oncology breast care, joint replacement specialist and ENT. Other specialist nurses included inpatient and outpatient pain nurses.
- Nursing staff had access to supervisors as part of preceptorship arrangements for new staff and ongoing

supervisory clinical support from line managers. Staff informed us their competencies were assessed as part of the safety checks on their skills and ability to undertake various patient interventions. For example, competencies around intravenous medicines administration, blood sampling and regional pain relief.

- Surgical staff had access to non-mandatory training relevant to their roles. For example we were advised that operating theatre practitioners had been trained to use cell salvage machines, used for the management of patient blood products. We saw too that 'Hot topics' were focused on as part of the staff development. Information around a subject matter of current interest was displayed on ward noticeboards for staff to view.
- Appraisal rates for medical staff reported via the clinical governance report dated February 2014 indicated 77% of orthopaedic consultants had received an appraisal during the period January to December 2013. We reviewed appraisal rates for consultants as reported via the clinical governance reports. ENT reported that as of May 2014 all had received an appraisal as had their associate specialists. In the clinical governance report for general surgery and urology dated January 2014 appraisal rates were reported to have been achieved to a level of 88% for consultants. Within anaesthetics it was reported that appraisals were 90% completed in the previous 12 months and there was a robust system in place with sufficient numbers of trained appraisers.
- The clinical governance reports for surgical areas indicated preparation for revalidation was in place and that revalidation was coordinated by a named individual within the trust.
- The Trust had been recognised for its contribution to teaching and trainee doctors reported high levels of satisfaction with the opportunities and experiences afforded to them. Trainees had access to for example, weekly lunchtime presentations and there was monthly deanery training for registrars.

Multidisciplinary working

- Nursing staff reported having excellent support from medical staff and a good working rapport with their colleagues. Communications and teamwork was in evidence in all interaction observed by us where multi-disciplinary staff engaged in discussion related to patient care and treatment needs. All participants were encouraged to contribute to discussion and there was equal respect to suggestions and opinions. We were able to observe in practice the engagement between members of the multi-disciplinary team (MDT) made up of occupational and physiotherapists and nursing staff on one of the wards. The MDT carried out a review of patient progress with a view to identifying progress and discharge dates.
- External MDT working within the cancer speciality was described to us by a nurse specialist. Arrangements were described for the MDT meetings held locally on a Wednesday, with specialist consultant, histopathologists and radiologists attending. A Friday meeting which was connected via network link to Royal Surrey County Hospital and included oncologists' participation in which patients with confirmed diagnosis and high levels of suspicion were discussed. We saw minuted meetings to confirm these discussions took place around the surgical needs of patients.
- We were able to observe the MDT meeting within the surgical team taking place as part of the shift handover. Participants included the outgoing/incoming surgical consultant, Surgical Acute Dependency Unit lead, pharmacist and matron who discussed patient diagnosis, results from investigative tests, current management and future requirements. This meeting took place in an area of the hospital which did not prevent confidential information being heard by restaurant staff, cash till operators and other circulating staff.
- Cancer peer review results had been consistently rated green for MDT working for the previous five years.

Seven-day services

- On call arrangements for consultants had been arranged so that a surgical consultant of the week was always available. This consultant had the overarching responsibility for surgery. In addition the surgical assessment unit (SAU) had a consultant based there between the hours of 14:00 and 19:00 to support junior staff as these were identified as periods of peak activity. Between night hours Tuesday to Thursday the consultant for the SAU was also on call and whilst surgery was taking place. Anaesthetic consultant cover out of hours was arranged to cover three hours per day at weekends. In addition there was consultant anaesthetist cover for CEPOD theatre working an all-day session and a second on call for additional theatre activity.

Surgery

- Consultant led ward rounds took place daily including weekends during which patient progress was reviewed by relevant multidisciplinary team members based on individual needs. Surgical outliers were reviewed regardless of location as part of the routine.
- Staff advised us the dietician was available on call out of hours and where they did not need to come into the hospital staff could access an on-site cupboard to provide dietician recommended products for immediate patient use. Discussion with an occupational therapist indicated there was a seven day service based on priority. Priority one was patients in A&E, then elective orthopaedic surgical patients, followed by all others. Physiotherapy staff were available via on-call arrangements outside of normal day time hours.
- Imaging and pharmacy services were accessible during open hours and via on-call arrangements out of hours, thus ensuring patients could receive any necessary interventions as required.

Are surgery services caring?

Good

The staff working in surgical services showed a caring approach to their patients. Patients described their experiences of the treatment and care positively, with many comments expressed to us of a favourable nature. Comments included: "I have had excellent care on every ward. I have been told all about my progress", "staff asked what I wanted to be called and offered help and support, they can't do enough." Patients told us staff respected their privacy and dignity and they also noted how caring staff were to others who needed more help.

The majority of staff were observed to be kind, caring and attentive to people's needs. Staff respected people's privacy on the whole, closing curtains around bed areas and shutting bathroom doors whilst personal care was being delivered. However, we heard confidential information being discussed as part of the nurse handover between shifts, which some patients may not have liked.

Patients told us they had been given information by doctors and nurses so they understood their treatment and care options.

Compassionate care

- Patients described their experiences of the treatment and care they were or had received whilst on the surgical wards. With one exception all comments made were positively expressive of the staff. For example, one patient told us "I have had excellent care on every ward. I have been told all about my progress." This person added the staff were most definitely "respectful towards me." Another person told us they came in via the A&E department and were seen within half an hour in triage. They said, "Nurses are lovely, explained all to me." They said they were seen quickly by the doctor and moved swiftly to a ward where they found staff to be "very good" in regard to respecting them and their dignity. We were told, "staff asked what I wanted to be called and offered help and support, they can't do enough." This person said they had noted staff being attentive to others and taking their time in particular to support a person who was hard of hearing. One person said the staff did not always respond to their call bell and as they were in a side room this made them feel "isolated." Patients who spoke with us on the day case unit said, "we couldn't ask for better service" and "the staff are wonderful", "we are very lucky to have such a good hospital."
- On all ward areas we visited we saw staff being kind and caring when dealing with patients. Staff took time to help those with care needs in a manner which was respectful and maintained their dignity. There was a level of appropriate humour and friendliness with patients who had been on wards for a longer period of time and sensitivity to those who had needs associated with cognitive impairment. In operating theatres we saw staff caring for patients with respect, observing as much privacy and respect for their dignity as possible.
- The sharing of sensitive information was not always fully respected by staff in the handover between staff shifts. For example, we were present for a shift changeover from night to day staff on one surgical ward. Verbal information was communicated at the bed area about the respective patients at a level which could be heard by others in the bay areas. We checked with two patients about this and whilst they were not unhappy about this we were concerned that patients who may not have been as aware of the extent of communications may not have been given a chance to say if they wished such information to be handled more sensitively.

Surgery

- The National Cancer Patient Experience Survey for 2012/13 included responses from 289 patients who had been treated at the hospital. The trust had responded within an action plan to the areas which needed to be improved. For example in respect to ascertaining the person's preferred name by which to be addressed and the provision of written information about the type of cancer they had and side effects of treatment. In each case the aim was to improve patient experience and actions had been identified with responsible individuals leading on this.

Patient understanding and involvement

- We saw each patient had been provided with a bedside information booklet to help them understand aspects of their care
- Some patients talked to us about 'their nurse' and we noticed the named nurse had their name above some patient beds, although this varied from ward to ward. Care records we reviewed did not always identify the named nurse; however, all written entries included the name of the nurse responsible for care delivery on the particular part of the day. Where we witnessed handover between shifts, we heard staff introduce themselves as the patient's nurse, and the team who would be caring for them.
- The majority of patients who spoke with us said they had been given sufficient information to enable them to feel involved in decision making about their treatment and care. A patient said they were "kept informed and told what was going on" as well as being updated with regard to progress and tests. Another patient said there was "good planning and organisation, the doctors have kept me informed of progress and the physio is very good."
- One patient who was being cared for in a single room for isolation purposes told us they hadn't been told the reason for this but thought they had "picked something up." This person said they were scared to mobilise using the provided equipment and was not confident in its use.

Emotional support

- Patients who spoke with us reported having a high level of confidence in the skills and knowledge of staff providing their treatment and care. One person said "the Army doctors are fantastic here", adding at the end of our discussion it's "excellent." Another patient told us "staff are second to none. One nurse was an example to all, explaining everything, thorough and considerate."
- Patients using the surgical areas had access to clinical nurse specialists, and we spoke with one gynaecology oncology specialist nurse who described part of their role was about supporting patient through the pathway of their care. They described supporting patients where their care was co-ordinated across two sites

Are surgery services responsive?

Outstanding ☆

The surgical service at Frimley Park Hospital was rated outstanding for its responsiveness to patients needs. Patients were reviewed by relevant senior personnel in order to ensure the local community needs were being met. New services were established where improvements were identified to be beneficial to people using the service.

In response to increased pressures on theatre times extensive work had been undertaken by the directorate to improve the productivity of the theatres available. Initiatives such as the 'Golden patient' and extending session times had led to significant improvements, such that the cancellation rates from October 2013 to June 2014 stood at an average of 0.6%.

People who had particular physical or mental health needs, including care needs associated with dementia were supported by staff that had been trained in these areas. The 'butterfly' scheme was seen to be active and work was in progress to further enhance the experiences of people with dementia needs. There was access to specialist advisers, including nursing and medical personnel.

Whilst very few complaints had arisen directly from the experiences of people who had used the surgical services, there were arrangements in place to respond to complaints in accordance with a local policy. Staff received information arising from complaints where they needed to change practice or address concerns identified from the review process.

Surgery

Service planning and delivery to meet the needs of local people

- Members of the surgical directorate team were working with the Clinical Commissioning Groups (CCG) at both clinical and director level at regular monthly meeting in order to review and plan the delivery of new services for the local population. Recent changes delivered in order to meet the needs of people included the development of vascular service, spinal services and ophthalmic specialities.

Access and flow

- Access to the hospital surgical team was made via a number of routes, including referral from the patient GP for consideration of the need for elective surgery, emergency admission via A&E, on request from the GP or by self-referral. Patients whose surgical procedure involved an overnight stay were admitted on the day of surgery to the pre-operative department 'POD' starved in preparation for surgery. Following their procedure they were taken to a ward-based bed for post-operative care.
- Bed management meetings took place at 08:30 hours and these were attended by the in-charge theatre personnel so they were aware of bed capacity issues. Senior staff reported patient placement was sometimes a problem and bed capacity was "tight at times", resulting in surgical patients not necessarily being on the correct ward prior to theatre. Scheduling of theatre lists had been reviewed and a mix of shorter and longer procedures had been found to be beneficial to flow. Monthly theatre management group meetings were used to discuss issues around capacity or issues which had impacted on efficiency of flow, such as porter availability. Staff explained how the 'golden' patient had improved the start of theatre lists. This involved ensuring the first patient on each list was prepared and available in the theatre department so the operation could start at the planned time.
- Bed occupancy figures at midnight were monitored for some surgical specialities and reported as part of the clinical governance procedures. Examples of reported figures included occupancy of 84% across the three combined orthopaedic wards in May 2014.
- Surgical cancellation rates on the day of surgery for non-clinical reasons were on average 0.6% between October 2013 and June 2014.
- Following a review of the theatre utilisation, the trust implemented five hour theatre sessions to allow more cases to be done on each list, to increase productivity and reduce the likelihood of cancellation or delay to patients.
- A day surgery unit had been opened to improve productivity and improve the patient experience for patients requiring day surgery. The views of patients were taken into account when designing the unit.
- The recovery unit had a service where patients who required extended recovery were booked in and their care provision was planned in advance, with staffing adjusted to reflect the care required. Discharge arrangements were considered and acted upon as soon as possible by clinical staff from the point of pre-assessment and thereafter throughout the patient journey. We saw the multi-disciplinary team actively engaged in the discharge process, for example in ensuring patients could; mobilise safely, understood their post-operative exercises and had provision for aftercare when returning to the community or their own home and equipment was required.
- Care of surgical outliers (patients who were on wards outside of the surgical directorate) was managed effectively with a formal system in place to identify where such patients were located. Information was communicated in daily handover of the patient location and medical staff ensured such patients were seen and reviewed until such time as they were repatriated to the most relevant ward.
- Discharge arrangements were co-ordinated at ward level but there was involvement of the senior nursing and multi-disciplinary team in making arrangements around complex needs. Staff reported that where community services were required these were arranged more effectively through the two on-site regional teams. Patients coming from the third referring area often presented difficulties in making arrangements for discharge in a timely and responsive manner. This resulted in the delayed discharge of medically fit people.

Meeting people's individual needs

- We saw each patient had been provided with a bedside information booklet. This was a freestanding glossy

brochure which contained details on for example; what to expect during the patient stay, who's who, food and drink, do not attempt resuscitation (DNA CPR), concerns and problems around safeguarding.

- Interpretation services were found to be available via 'Language line' and information about accessing this was outlined in the 'Your bedside guide'. We were informed that work had been undertaken with the local Nepalese community and there were a number of staff trained up to support the delivery of information for those individuals who had reduced English language skills.
- We were provided us with a copy of 'The Frimley System Dementia Local Implementation Group' (DLIG) draft strategy for dementia services. This was seen to set out the expectations of the multi-disciplinary representatives across teams of health professionals from the local health, social care, third and voluntary sector, with the aim of improving dementia care. This DLIG was one of five across the county of Surrey, each one feeding in to the Surrey Dementia Partnership Board as well as each of the local System Transformation Boards. Within the strategy we identified four aims associated with hospital related surgical service provision including: Ensuring older people with dementia were only admitted to hospital when there was a clear reason to do so and to improve discharge planning in order to reduce the length of stay. To improve the hospital environment for patients who have dementia. Improve staff awareness, understanding and education about dementia. Improve the skills and services available in hospital to meet the needs of people with dementia. Information was accessible in a range of formats and translation and audiology services were available to support the delivery of information. We found the surgical areas had already made progress on delivering the dementia strategy and arrangements to meet the individual care needs of people living with various forms of dementia had already been put in place. We saw the recognised national 'Butterfly' scheme was in place on surgical wards, with respective patients identified using a butterfly to alert staff. This scheme used a blue butterfly to signify a diagnosis of dementia. A butterfly in outline only was used to indicate the person had a degree of confusion but no formal diagnosis had been made of dementia. A 'This is me' booklet was provided for completion in readiness for admission at the pre-assessment stage. This booklet enabled people living with dementia or the person who knew them best to provide information which would assist the staff to provide the right level of care and support.
- Staff had access to dementia champions' who had a responsibility for ensuring the needs of people with dementia were being addressed and that information from the dementia steering group was cascaded appropriately and effectively. Staff confirmed they had mandatory training on the subject of dementia.
- Within the orthopaedic ward areas we saw tables had been placed near windows to enable people who wished to sit and view their surroundings. A communal dining table enabled people to dine in company, rather than at their bed area. A news information update titled 'The Daily Sparkle' was made available for people who were living with dementia. We saw memory boxes in place for two people, which were provided as a means to keep familiar items close to their person.
- Specialised equipment was available for bariatric patients use and there was access to other services in order to meet people's individual needs.
- The trust internet provided a whole range of information to inform patients and the public about the services and arrangements within the hospital. In addition to this staff provided verbal information, further enhanced by easy access to a range of informative leaflets in each surgical area. We selected and reviewed a number of these including; information about the pre-operative assessment clinic, leaving hospital, emergency operating theatre, angioplasty and surgery for carotid artery disease. We also saw a number of ophthalmic specific information leaflets such as blepharitis, low vision clinics and age related macular degeneration. All leaflets were written in a manner which helped the reader to understand the area or disease process and treatment. Leaflets could be obtained in large print, Braille or audio versions by contacting the patient advice and liaison service. There were links to the trust on line website as well as names of relevant specialist nurses.
- There was a trust Learning Disability (LD) liaison nurse who reviewed patients who had LD following admission. The trust encouraged the use of care 'passports' to ensure that staff had as much information and background about the individuals during their stay. Carers input and feedback was encouraged and used to improve services.

Surgery

Learning from complaints and concerns

- The patient bedside information booklet contained details about making a complaint. We saw too that information was prominently displayed to advise people how to complain and accessing the Patient Advice and Liaison Service (PALS).
- Staff were very aware of the complaints process and indicated they were provided with regular information as to their ward/departments respective concerns. We saw on our visits to wards feedback on display which indicated no complaints for the previous month in most cases.
- Complaints data for surgical areas was collected, compared and reported as part of the clinical governance process. We saw for example in the report dated February 2014 that in orthopaedics there had been 31 complaints up to the end of November 2013. For ophthalmology 12 complaints had been made in 2013/14. The most common reason for complaining related to communication and discharge arrangements as well as appointments. Within anaesthetics there had been only four complaints thus far year to date, two of which did not relate to surgery.
- Feedback from the 'Friends and Family' test results were visible on all wards visited by us. Along with complimentary feedback and overall high levels of recommendation, we saw examples of feedback on areas for improvement. This included a comment on the noise levels at night on F4 and action taken to resolve this, which included raising staff awareness and settling people earlier and turning lights off. On ward F7 we saw feedback included a request for televisions and improved arrangements for take home tablets. Action in response to this included the installation of televisions in late August and doctors were to write up take home medication in a timely manner.

Are surgery services well-led?

Outstanding ☆

The surgical services were led by a highly committed, enthusiastic team of staff, each of whom shared a passion and responsibility for delivering a first class service.

Leadership was said by staff to be "excellent" and "visible." One comment made was that there was a "general feeling of good leadership, with forward thinking people and an emphasis on patient care and effectiveness."

Staff understood the ethos of the service, the corporate values and demonstrated a commitment to delivering a quality service to the patients. Speciality services within surgery had identified their own objectives and there were systems in place to monitor progress and report on these to the Trust Board.

Governance arrangements enabled the effective identification of risks, monitoring of such risks and the review of progress on action plans. Regular detailed reporting enabled senior managers and representatives of the Trust Board to be aware of performance and where improvements had positively impacted on service delivery.

The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the surgical directorate. As an innovative organisation the surgical division was engaged in a number of research trials and had contributed to the body of knowledge in relation to a number of surgical specialties. Trainee doctors considered the trust to be an excellent place to gain experience in surgery and reported effective supportive networks.

Vision and strategy for this service

- Directorate objectives for 2013/14 had been set out for the surgical division, including integration plans for ENT, upper gastro-intestinal, vascular, general surgery and urology. We reviewed the information supplied and noted objectives set out to address service delivery for example; capacity, infrastructure, length of stay, reduction of readmissions, improved theatre utilisation, and increasing patient satisfaction. We saw more specific objectives such as within the vascular team, the development of an interventional Radiology service and developing a centre of excellence. Objectives had been assigned a directorate lead and were rated using a traffic light system in regard to the delivery risk, with commentary to support each entry and target dates in most instances.
- Staff we spoke with had a clear understanding of the trust's vision and strategy. This included the possible acquisition of nearby Heatherwood and Wexham Park Hospital. We found there was a genuine sense of commitment towards the underpinning values.

Surgery

Governance, risk management and quality measurement

- The trust had a Clinical Governance Committee (CGC), which was attended by executive directors and one Non-Executive Director and up to one governor. The CGC had a responsibility for reviewing the clinical governance framework of the trust and providing assurance to the Board through the medical director to assure best practices and regulatory requirements were being followed. Meetings were minuted and we saw from examples of such minutes participants reviewed topics including; risk reports around incidents, complaints, mortality and morbidity, antibiotic audit compliance and medicines management from the surgical areas.
- Clinical governance reports were produced within the surgical directorate and we reviewed governance reports for general surgery and urology and ENT. Reports were extremely detailed, identifying key achievements. For example, within the general surgery and urology achievements reported for 2013, VTE assessment and prophylaxis had improved in general surgery exceeding the target level of 95% from June to the end of November 2013. The clinical governance report for ENT indicated positive progress in a number of areas such as, 100% compliance with WHO checks and VTE assessments year to date at 93.6%.
- We saw evidence of the process for reviewing serious incidents (SI). The corporate governance group reviewed all information pertaining to SIs which related to the surgical services, for example inpatient fall with significant injury. We noted from summarised reports from such reviews findings were identified, along with recommendation and the implementation of an action plan. The latter defined responsible individuals, target dates and the method of evidencing the actions taken. Staff were able to describe an example of a SI which had occurred on a surgical ward, the process for investigating this and resulting actions, demonstrating to us the effectiveness of the process.
- The surgical directorate had effective arrangements in place to respond to Regulation 28 Report, Action to Prevent Future Deaths, from HM Coroner. We reviewed information provided which indicated the staff in the surgical services undertook a thorough process of addressing concerns raised by the Coroner, including action taken to make improvements. For example, surgical staff had increased the functions of the post-operative follow up part of the enhanced recovery pathway by introducing the surgical assessment unit 24 hour helpline and implementing a colorectal discharge follow up call record sheet.
- Local risk registers were in place for the surgical directorate which assisted the corporate governance group to identify and understand the risks rated using a colour coded system according to low risk through to moderate, high and extremely high. We saw from the risk registers supplied risks had been described in a manner which linked them to the trust board objectives, mitigation had been described, the actions taken and the lead person. The most recent rating of the risk had also been identified. Additionally, risk management reports were provided by surgical services and we saw these identified incidents for each surgical area by month, with graphical charts displaying trends. The top five categories which triggered an incident had been identified, such as pressure sores, falls and bed availability. We reviewed information which indicated the description of the incident and subsequent action taken, plus the resultant outcome where known.
- There was a proactive approach to monitoring and measuring various aspect of quality throughout the surgical directorate. Dashboards were seen to be populated with data pertaining to a whole range of indicators in line with the five domains of safety, caring and effectiveness, responsiveness and well-led, some of which are reported in previous sections of this report.
- The trust executive board had a responsibility to review performance against the quality indicators on a monthly basis. Monitoring was carried out through the quality performance dashboard and the board received progress updates against any improvement projects.

Leadership of service

- We were told by staff they were very happy with the leadership availability and responsiveness. The head of nursing was described by one member of staff as “very approachable, visible and very good.” A member of the senior nursing staff said they had “excellent leadership from my line manager” and added there was a “general feeling of good leadership, with forward thinking people and an emphasis on patient care and effectiveness.” Staff felt confident in the senior leadership and reported having access to senior personnel, feeling listened to and valued for their contributions.

- The trust had a 6-month leadership programme for senior sisters, which was in partnership with the military, in order to strengthen their role in the delivery of high quality patient care. Some of the surgical nurses stated that they recognised the positive impact this had made to them as leaders.

Culture within the service

- Staff reported how "proud" they were about the service they provided. Other staff said they were very happy to part of the' Frimley' team and said the culture was one which was supportive and friendly. A staff nurse told how they previously worked as a healthcare assistant and how they had been supported to undertake their nurse training. They told how supportive line managers were, telling us they had opportunities for daily discussion about any concerns and general work activity.
- We observed an open, considerate and respectful culture, which was inclusive and had at its heart an ethos which reflected the values espoused by the executive team.

Public and staff engagement

- The Trust had a Patient Experience and Involvement Group (PEIG), which was a sub-group of the Council of Governors (CoG). The PEIG was meeting quarterly to provide feedback to the Trust and the CoG on matters relating to service developments and patient experience. Amongst the activities of this group members took part in quality assurance walkabouts, visiting surgical wards and reviewing surgical ward clinical indicators, and speaking with patients about their experiences. They also discussed at these meeting a number of surgical related areas, including: Discharge planning and readmissions in surgery, appointment times for macular patients in ophthalmology, and the breast care seminar and a presentation on robotic surgery. We saw minutes of meetings, which confirmed the activities of such group discussions.
- The trust had a range of standing and project groups and committees, which involved staff in making decisions about future developments. For example, the trust had a staff council which met regularly to provide regular consultation between managers and staff representatives and was intended to support a constructive and co-operative approach towards achieving corporate goals. The council had looked at the issue of staff retention in theatre and made the decision to introduce an incentive to address this.

Innovation, improvement and sustainability

- In 2013 the trust developed a new innovation and change team to support the trust corporate and operational strategy. Examples of areas being focused on by the trust included; reducing unnecessarily long stays in hospital for surgical patients, ensuring patients received effective care at the right time, in the right place and, reducing the number of re-admissions to hospital following discharge home after surgery.
- Within the surgical division it was noted the extent of the research and training programmes, which included presentations at international learned societies. The National Institute for Health Research, (NIHR) Clinical Research Network reported that the trust had increased their number of studies from 39 in 2012/13 to 62 during 2013/14. The ophthalmic directorate had been awarded the team of the year from the research department.
- Innovative actions taken by the surgical directorate included the establishment of a macular service for ophthalmic patients. This included a mobile unit facilitating an accessible service as near to the patient as possible. The trust had also achieved the best secondary care provider in respect to achieving targets for diabetic retinopathy. We also reviewed information which related to innovative practice for robotic assisted rectal surgery.

Critical care

Safe	Outstanding ☆
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆
Overall	Outstanding ☆

Information about the service

The Intensive Care Unit (ICU) was a 12-bed facility with nine Level 3 intensive care beds and three Level 2 high dependency beds. The unit also had four overnight or extra capacity beds in the post-anaesthetic care unit (PACU) which were managed by the ICU team and staffed by multi-skilled, critical-care trained staff.

The trust also had a Medical Acute Dependency Unit (MADU) consisting of eight beds. These could be flexed to accommodate Level 1 or 2 patients depending on clinical need. Non-invasive ventilation was provided in this unit as well as one type of inotrope (medication which can be used to support the heart). This unit had recently been moved to an area next to the ICU, previously having been situated on the respiratory ward.

Patients are admitted to ICU from the emergency department, theatre complex, PACU, wards or other departments in the hospital. The unit also supported the trust's role as a tertiary provider for regional vascular services, regional primary percutaneous coronary intervention (PCI) services and as a post cardiac arrest centre, and consequently received patients from throughout the region.

Summary of findings

Overall we rated critical care services outstanding. The patients we talked with told us of the "good reputation" the service had in the locality and also that they felt "very safe" when using its facilities.

Patients had access to a bereavement service and annual memorial service to remember their loved ones. The unit had implemented the use of 'patient's diaries' and a psychology service was provided. Relatives of patients who remained on the unit for more than one week had a meeting with the matron of their service to ensure any concerns they had would be addressed.

The unit delivered a consultant-led service with two consultants providing medical cover. One consultant was solely dedicated to being on site from 8am until 10pm daily. The other consultant provided support to the critical care outreach team and covered the unit on an on-call basis from 10pm until 8am. There were resident facilities provided for consultants who lived more than the recommended 30 minutes away from the hospital. There was nine hours of on-site consultant cover provided at weekends. The unit never used locum doctors to cover unexpected vacancies. Medical oversight of the MADU was primarily by respiratory consultants with support from their intensive care colleagues when required.

Use of agency nursing staff was below the acceptable minimum rate set by the trust, and all agency staff were subject to a strict recruitment and induction process

Critical care

which mirrored the trust's own recruitment policy. The unit had also rolled out first Advanced Critical Care Practitioner training programme, one of very few nationally and the first regionally.

All aspects of care delivered in the unit were audited and reviewed to enable continuous improvements. The unit had implemented extra quality and safety measures to ensure it was delivering a high quality service in line with national guidance. The unit could demonstrate that it was achieving low mortality rates and good patient outcomes when compared to other units of a similar size. We found an open and transparent approach to incident management and a real focus on learning from these events through root cause analysis and peer review processes. There were continuous data submissions to national audits and participation in research programmes on the unit.

The unit was innovative. For example, it had implemented cardio pulmonary exercising testing and Intra-aortic balloon pumps. It regularly contributed to the CCN (Critical Care Network), RCN (Royal College of Nursing) and BACCU (British Association of Critical Care Units).

We found there was a real commitment to delivering multidisciplinary care and the nursing staff worked flexibly to ensure that a quality service could be delivered safely during busy times. Staff felt valued and supported by their teams and by senior management. They told us they received appropriate training to enable them to meet people's individual care needs. Staff discussed the continuous learning culture on the unit and how they felt supported to engage in continuous personal development.

Staffing levels were continuously reviewed using the unit's staffing acuity tool and we found the staffing levels to be adequate to deliver the service.

The environment was cleaned to a high standard and the trust's infection control policy was being complied with. The unit demonstrated safe medication management and we saw adequate supplies of equipment to meet patients' care needs.

Frimley Park Hospital also incorporated a Ministry of Defence Hospital Unit, with fully-integrated military medical and nursing staff contributing to patient services. A member of staff told us "Frimley has one of the best places for military/civilian integration."

Critical care

Are critical care services safe?

Outstanding ☆

We have judged the services delivered at Frimley Critical Care Unit (CCU) and Post Anaesthetic Care Unit (PACU) to be safe.

The service demonstrated effective systems and a transparent culture to reporting, investigating and learning from incidents**.**

Patients benefited from safe, quality care, treatment and support. We saw peoples' care needs were assessed, planned and delivered in a way that protected their rights and maintained their dignity. The care plans we reviewed demonstrated that care was risk-assessed. Where a risk was identified, it was managed effectively and reflected the individual patient's needs and circumstances.

The hospital used a Medical Emergency Team score to identify and monitor deteriorating patients.

Incidents were reported, monitored, investigated and learned from in accordance with national guidance. There was a multidisciplinary approach to incident review and Morbidity and Mortality reviews were routinely held. Medicines management in the unit adhered to Trust policy. Staff had received competency-based training to administer medications.

We saw an ample supply of equipment and consumables to meet peoples' care needs. Equipment was cleared in line with the infection control policy. There was a sufficient supply of Personal Protective Equipment (PPE) which was being used by staff before any care interventions were undertaken.

There was an appropriate major incident plan in place and staff we spoke with were aware of their role should a major incident be declared. The plan was tested during the recent 'flu pandemic and was deemed robust.

Guidance from the Intensive Care Society (ICS) advocates that all Level 2 and Level 3 patients should be cared for in a 'closed unit' (i.e. in one area) and that medical oversight of the unit should be by intensive care physicians. Frimley Park Hospital had Level 2 provision on the MADU, the governance of which sat under the medical directorate rather than that of the critical care. However, there was daily presence from the ICU, both in terms of ICU consultants and the critical care outreach nurses twice daily. The lead nurse for the unit has an extensive background in critical care nursing and 40% of the nursing staff had undertaken further training in caring for acutely unwell patients. The unit is staffed according to ICS standards for Level 2 patients and the respiratory physicians (most of whom had undergone specific training in intensive care) undertook ward rounds seven days a week. Outcomes for the unit were closely monitored and mortality and length of stay data was seen to have improved year on year (comparative data with other units at present does not exist on a national basis).

Incidents

- We reviewed evidence that confirmed incidents were reported, investigated and learned from in the unit. Documents we reviewed demonstrated a robust and effective investigation processes.
- The unit had a staff communication system at handovers where "hot- topics" and learning from these incidents were discussed. We saw documentary evidence on our inspection of hot-topic learning where lessons learned from serious incidents were being disseminated to staff three-times a day for a one week period. Staff we spoke to were able to tell inspectors what the hot-topics were and the lessons learned from incidents.
- Incidents reported that involved military personal were reviewed by the military governance personnel. This meant that two review processes were in place to ensure learning and avoidance of recurrence from any incidents.
- We saw evidence that the unit held morbidity and mortality (M&M) meetings on a monthly basis and we found a multidisciplinary approach to reviews. Data from these meetings was escalated to board level as required and M&M activity and actions were formally recorded.

Safety thermometer

- The Safety Thermometer was in use at the unit and the information was displayed for patients and relatives to view.
- Staff were able to tell us the rationale and importance of that collection for the safety thermometer and could discuss how it was used to improve the service delivered.

Critical care

- Data reviewed from September 2013 – April 2014 showed 100% compliance with harm-free care.
- The unit has reported 159 days since the last pressure sore was identified and 100% of patients had had their Venous Thromboembolism (VTE), risks assessed.
- Patients had appropriate risk assessments in place for pressure ulcers, falls and malnutrition. These risk assessments were carried out using an electronic system and were reviewed regularly at appropriate intervals.
- We saw safety measures in place that were above the recommended safety thermometer data set. Examples of this included transducer fluid checks, medication infusion rate checks, ventilator safety parameter checks, and ET tube cuff pressures.
- The unit had implemented an extra safety care bundle that was reviewed daily on the daily ward rounds by the consultant and then later checked by the nurse in charge to ensure that all aspects of patient safety was reviewed daily.

Cleanliness, infection control and hygiene

- At our inspection we found it was 1409 days since the last MRSA bacteraemia was identified, and 298 days since the last case of C difficile.
- We reviewed documentation that demonstrated that identified MRSA's and C difficile infections had a Root Cause Analysis (RCA) carried out.
- Our observations of the clinical areas during the inspection showed a meticulously clean clinical environment.
- We reviewed other areas including the sluice, blood gas analyser and administration station and relatives waiting areas and also found them to be very clean and tidy.
- Needle sharp bins in the areas were no more than ¾ full and all the bins we looked at were dated and signed by a member of staff in line with policy.
- Cleaning logs were available to view, up to date and regularly audited by the nurse in charge of the shift.
- Records of cubical curtain changes were available for us to view.
- We observed staff adherence to infection control policy and saw then use Personal Protective Equipment (PPE) when delivering personal care. The relatives we spoke to told us that the staff always wore PPE when caring for their loved ones.
- Staff told us that they always had access to an ample supply of PPE and other disposable consumables.
- We reviewed documentary evidence that demonstrated a very high level of compliance with infection control interventions.
- We also reviewed documents that told us the unit's compliance with infection control policy was independently audited and reviewed by the hospital infection control team to ensure compliance. This provided another level of quality assurance regarding adherence to trust policy and best practice. The audits undertaken by the unit and then validated by the infection control team had a 100% compliance rate, demonstrating high standards.
- Staff training records demonstrated that 96 % of nursing and medical staff had completed infection control training.
- Members of the senior medical and nursing team attended the trust-wide multidisciplinary team infection control meeting representing the unit
- We found Ventilator acquired phenomena (VAP) and (Central Venous Catheter (CVP) infection rates were audited in compliance with the DOH (Department of Health) 2012 'Saving Lives' guidance. The national standard for central line infection rates is 1.4/1000 bed days. The unit's rates were consistently below this for a two year period.
- We saw there was a physical barrier between bed spaces to reduce cross space contamination.
- Both the Critical Care Unit and the PACU had an infection control link person who attended the quarterly infection control forum.
- Sinks and showers were flushed daily to avoid a build-up of pseudomonas; a known infection hazard.
- All patients in the unit had their MRSA status checked. We saw appropriate use of isolation cubical for patients who required isolation because of an identified infection risk.
- We observed patients who were able to eat normally were assisted to clean their hands before meals.

Environment and equipment

- We judged patients and staff were not at risk of harm from unsafe or unsuitable equipment.
- The unit had an ample supply of the equipment required to meet patients' care needs. We saw records

which demonstrated equipment maintenance and regular services. However, we noted that some of the equipment was old and required a considerable financial investment to replace.
- The staff we spoke to confirmed that they always had access to the equipment they needed to do their jobs.
- We noted that the all the equipment had stickers in place stating the date and the member of staff who was responsible for its cleaning.
- Resuscitation and emergency/difficult intubation equipment was available and staff were aware of its location in the event of an emergency. We saw that this equipment was checked regularly and the records reviewed did not have any gaps which showed a consistent and regular approach to safety checks.
- Regular and temporary staff all received the necessary training to ensure they were able to use the different types of equipment available to them.
- The unit has a dedicated technician who ensured device availability and compliance with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance.
- We identified that equipment storage was a concern on the unit. We discussed this with the nursing team who told us about their coping strategy, but they agreed that it was an ongoing issue.

Medicines

- We judged the provider protected patients against the risks associated with the unsafe use and management of medicines.
- The provider had systems in place that demonstrated compliance with the medicines act 1968 and the Misuse of Drugs Act 1971.
- We found people had their medications administered at the times they needed them.
- We observed staff administering medication in a person centred way and saw the appropriate checks were being carried out.
- Medicine Administration Records (MAR) were reviewed and found to be fit for purpose. They adhered to national prescribing guidelines.
- When a medication was omitted a reason for the omission was clearly documented.
- Medication compliance in the unit was audited regularly; data was acted upon and was subject to an external audit process by the Trust pharmacy team. The pharmacy department performed quarterly audits to identify the percentage of prescriptions that met the needs of specific care bundles. The documentation we reviewed showed 100% compliance with the stop/review dates, indications stated and whether the prescribing followed trust guidelines.
- Controlled drugs (CD) were handled appropriately and stored securely. A spot check on the CD stock and records demonstrated compliance with relevant legislation.
- The staff we talked with told us they felt confident and competent to administer medication. Records demonstrated compliance with a competency based medication training programme.
- At our inspection we saw it was 26.7 days since the last medication related incident.
- Nursing staff who have been involved in a medication error attended a medicines management module delivered by the unit. Medical staff were requested to complete medication reflection when involved in a medication error.
- Antibiotic prescribing standards prescribing was regularly audited and showed a high level of compliance with national best practice
- The unit had a nominated nursing representative on the e-prescribing committee and there was consistent unit representation at the Trust safer medicines committee.

Records

- Records were stored in a secure way that promoted confidentiality.
- We reviewed a random sample of clinical notes. We also observed the quality of the historical recording and the quality of recording during a ward round. The records we reviewed were legible and accurately filed in chronological order. This demonstrated a cohesive approach on the management of patient's medical notes.
- The notes we viewed demonstrated personalised care and treatment with a multidisciplinary input.
- We noted there was written evidence of regular communication with relatives and loved ones.
- The administration staff we spoke to told us that clinical notes were easily available and rarely inaccessible. There was an electronic note tracking system in place to aid traceability.

Critical care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We judged that patients could be confident that the provider had systems in place to gain consent and that their human rights would be respected whilst in the unit's care.
- The notes we viewed demonstrated that consent was obtained when it was at all possible.
- The relatives we spoke to told us that they felt fully informed and where appropriate when a patient did not have capacity to consent that they were given enough information to make decisions on their loved one's behalf.
- We saw patients on the unit had their mental capacity assessed as their conditions changed.
- We saw one patient was assessed as not having capacity prior to our inspection. As their condition improved we saw the unit had taken the appropriate steps to re-assess their capacity. This demonstrated the unit was adhering to mental capacity best practice guidance.
- The Trust's Deprivation of Liberty Safeguards (DoLS) policy and the implications for the Critical Care Unit was under review at the time of inspection.
- Training records demonstrate that 100% of staff had received DoLS training at an appropriate level.
- The unit employed the use of mittens to ensure patient safety when they were needed. There was a policy in place on the safe use of restrains in the unit. The use of mittens was always discussed with relatives. They were used as a last resort and a risk assessment carried out before they were used. The decision to use mittens was only ever taken using the "best interest" clinical decision making process. Patients who required mittens had them removed every two to three hours to ensure that no harm came to them. These observations were recorded and reviewed regularly.

Safeguarding

- We found the unit had an appropriate safeguarding vulnerable and children's policy in place.
- The staff we talked with demonstrated a good knowledge of what safeguarding meant in practice and were able to tell us the escalation process to raise a safeguarding concern.
- Data reviewed in the critical care dash board showed seven safeguarding referrals were made for patients in a three month period. This demonstrated staff were identifying and reporting safeguarding concerns according to the policy.
- 96 % of the Critical Care Unit and 100% of the PACU (Post Anaesthetic Care Unit) staff had received the in-house training in safeguarding adults at risk.
- We noted that staff had not completed the safeguarding of children training. However, we were shown evidence that this training had been put in place by the trust and that staff had been booked to attend.

Mandatory training

- We were shown the staff training matrix in place on the unit. This matrix demonstrated that all mandatory training had a high attendance rate of 96%.

Management of deteriorating patients

- The hospital used a standardised MET score to identify deteriorating patients that require input from the critical care outreach team. These patients would be assessed by the critical care outreach team and a decision made regarding the ongoing care required and whether they needed admission to the critical care unit. The MET score is an assessment tool that enables the early identification of deterioration in a patient's condition.
- We saw evidence of patients with elevated MET scores being reviewed and all clinical interventions were clearly recorded when an escalation in care was triggered by the elevated MET score.
- Once patients were admitted to the critical care unit the MET score was not used as they were transferred over to the relevant critical care documentation. Staff we spoke with were able to describe the actions they would take when they identified a patient's condition was deteriorating within critical care unit.
- When a decision was made that a patient was fit for discharge from the critical care unit they would be commenced on a MET score to ensure there was a baseline prior to leaving critical care for the ward to continue monitoring against.
- Patients who deteriorated on the hospital wards during the hours of 8am – 10pm had access to an outreach team and critical care unit consultant review. Out of hours, patients were reviewed by the night nurse practitioner and the physician on call. The outreach service also provided support for any medical emergencies and cardiac arrests that occurred.

Critical care

Nursing staffing

- The nursing staff we talked with expressed confidence with the current staffing numbers. They told us they felt they were sufficient to meet peoples' individual care needs.
- The nursing staff rotas demonstrated a low use of agency staff. This showed compliance with best practice guidance which suggests no more than 20% of agency staff is employed on any one shift.
- The department used a staffing acuity tool to assess the unit's staffing needs.
- Staffing levels were reviewed three times daily to ensure the appropriate levels of nursing input the unit.
- This staffing acuity tool was developed was being implemented into other departments of the hospital as it was recognised as representing good practice.
- A band 7 (senior staff nurse) was allocated to every shift ensuring senior cover 24 hours a day.
- The department had systems in place to address the risks associated with using agency/bank staff. This incorporated a robust recruitment and induction process which mirrored the trust's permanent staff recruitment policy. This process was undertaken by the matron and senior sisters in the unit and included formal interviews, reference checks, training records review, skill and equipment competency checks and identifying key areas for learning before an agency staff member would be permitted to work in the clinical area.
- The unit also had a process for filling virtual vacancies. This meant that if there was prior knowledge of permanent staff member going on maternity leave for example, their post could be backfilled by the pre-vetted and inducted temporary staff who had already adjusted to working in the critical care unit environment. This ensured continuity and consistency from a patient care and employee perspective. We saw documentary evidence that this process was in place on the unit.
- To ensure adherence with the flexible working policy the department reviewed staff's working hours and preferred working patterns annually. Each staff member had their preferred working patterns compared to the needs of the department to ensure safety was not compromised. We reviewed a large sample of documentation that evidenced these annual reviews.
- We saw evidence that new staff had a hospital induction which was followed by a four week clinical supernumerary period on the unit. They were allocated a mentor.
- New staff were subject to competency assessments to ensure they were confident in using the many different forms of perfusion devices, ventilators and infusion pumps.
- The unit had the following whole time equivalents in post:

1. Band 8a x 2, band 7 x 3.6, band 6 x 21.27 band 5 x 29.68, band 3 x 1.8,
2. Band 2 x 4. We noted the service was contracted to have two whole time equivalent military nurses but had a total of six at the time of the inspection which meant additional staff above the funded establishment were available to provide the service.

- From our observations, the rotas we viewed and the conversations we had with staff on the critical care unit and PACU, we found an appropriate staff numbers and skill mix in both clinical areas.
- The unit has a structured nursing handover three times a day which included any changes to the care and treatment of the patients.
- Each staff member worked in a link-practitioner role which promoted educational development and promoted specialist condition-specific knowledge within the unit team.
- The unit whiteboard was visible and highlighted the person in charge of the unit and gave the expected and actual staffing numbers on a particular shift. This meant that relatives could be aware of who was on duty and the person in charge at the time of their visits.

Medical staffing

- The consultant to patient ratio was 1:12 which was in accordance with national recommendations of 1:14 Medical cover was delivered by 10 consultants who were resident on the critical care unit for 15 hours a day on weekdays and 12 hours a day at weekends. Consultants worked in four day blocks, which was in line with national guidance for intensive care.
- Three trainee doctors provided medical cover during the day and one provided cover at night, with on call consultant support after 10pm.

Critical care

- A second consultant provided support for cardiac arrests and medical emergencies that may occur elsewhere in the hospital.
- The staff we talked with during the inspection expressed satisfaction with the level of medical staffing cover and junior doctors felt "very supported" by their seniors.
- There were two medical handovers and a consultant ward round twice every day as a minimum.
- We found evidence of effective medical handovers. We noted a verbal handover in the mornings on the unit which was them followed up with bedside ward round. A written update for each shift was available for staff to refer to and a further handover of patients occurred at night. The junior doctors we spoke to told us that they considered the handovers of patients to be thorough and effective. The unit did not use locums to cover unexpected vacancies. If cover was needed then it was provided by a member of the critical care unit junior doctor or consultant team.
- In a patient survey, 82.50% of relatives reported being given the opportunity to talk to a doctor.

Major incident awareness and training

- We reviewed the major incident policy and procedures and saw the trust had an appropriate major incident/ business continuity plan in place.
- The staff we spoke with could tell us their role in managing a major incident and expressed confidence in doing so.
- This plan was tested during a recent 'flu pandemic and was deemed robust.

Are critical care services effective?

Good

From the data reviewed, our observations and the conversations with staff we judged the service delivered in the CCU to be effective.

We found the care delivered in the department to be evidenced based and adhering to national and best practice guidance. Care delivered was routinely measured to ensure quality and improve patient outcomes. The unit's mortality rate is currently 0.7% and is one of the lowest when compared to units of a similar size. The department was able to demonstrate that it was continuously meeting and exceeding national quality indicators.

Patients had their pain and nutritional and hydration care needs continuously assessed and met.

All new staff were provided with an extensive induction programme, allocated a mentor and underwent competency based assessments to ensure they had the skills necessary to do their jobs.

There was strong evidence of a multidisciplinary and multi-professional working in critical care. Allied health professional support was available 24 hours a day.

Evidence-based care and treatment

- The unit used a combination of national guidelines to determine the treatment they provided. These included guidance from NICE, Intensive Care Society and the Faculty of Intensive Care Medicine.
- The unit had a critical care delivery group which provided continuous reviews of the service including length of stay, bed capacity and the use of buffer beds.
- Documentation we reviewed showed only one patient transfer to another hospital for a non-clinical reason in a five year period.
- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- We also saw evidence suggesting that patient pathways reflected national guidance and were continuously audited. When necessary, action plans were implemented and re-audits undertaken to improve patients outcomes and the unit performance.
- The unit had a physiotherapist-led ventilator weaning programme in place. This Multidisciplinary Disciplinary Team (MDT) approach to care meant that care delivered was more effective and may have an impact on length of stay.
- Patients benefited from the availability of an exercise bike for rehabilitation purposes. Its provision meant that patients could improve their general fitness and increase physical strength which facilitated more effective weaning from mechanical ventilation.
- The department had implemented cardio-pulmonary exercise testing pre assessment and information giving clinics. There were two clinics a week which were led by PACU nursing staff. The rationale given for these clinics was, "In the pre-operative assessment clinic, aerobic fitness can be estimated with the incremental shuttle

walk test or more precisely quantified with cardiopulmonary exercise testing (CPX) which can also diagnose whether aerobic performance is limited by pulmonary, cardiac or peripheral disease, and may be a good screening test for ischaemic heart disease" in line with guidance from The Association of Anaesthetists of Great Britain and Ireland, 2010.

- There was also evidence that it participated and contributed to research programmes and audits outside of mandatory submissions. However, we noted the hospital did not participate in the National Cardiac Arrest Audit.
- The unit had the highest rate of organ donation in the region.
- The unit had implemented the use of capnography for all ventilated patients. This meant that patients had continuous monitoring of the concentration or partial pressure of carbon dioxide in the respiratory gases.
- We saw evidence that all sedated patients had a sedation hold daily. This meant that sedation infusions were stopped to ensure that patients had their level of sedation assessed in line with best practice guidelines.

Patient outcomes

- The average length of stay for patients in the unit was 4.8 days.
- We noted data contributions to the ICNARC database. Results from ICNARC showed that patient outcomes and mortality for the last few months to be within expected ranges when compared with other similar services' data.
- Unplanned readmissions rates to the unit were low and accounted for one patient a month.

Pain relief

- The critical care unit and PACU used a standardised pain scoring tool.
- The patients we spoke to in the critical care unit and PACU told us that their pain was continuously assessed and managed effectively and well controlled.
- Patients we reviewed showed that patient's pain levels were assessed regularly. They also demonstrated that pain relief was administered when required.
- The critical care unit meridian patient survey suggested 85.71% of patients were satisfied with how their pain was managed during their admission on the critical care unit.

Nutrition and hydration

- We found that all patients had their nutritional needs assessed and we saw patients had their weights monitored.
- All patients had the input of a dietician into their care and patients received an appropriate feeding regime as soon as it was feasibly possible. We saw patients receiving Total Parenteral Nutrition (TPN) and Percutaneous Endoscopic Gastrostomy (PEG) feeds whilst on the unit in line with local policy.
- Assessments that used the Malnutrition Universal Screening Tools (MUST) were found to be in place. Feeding regimes were reviewed and adapted appropriately to reflect individualised care. Safety checks for feeding routes and appropriate TPN storage were carried out.
- We saw strict fluid monitoring in place for patients which demonstrated hourly and daily input and output totals for all patients. Patients who were able to take oral fluids had their input encouraged and unconscious patients and their circulatory volumes continuously monitored via CVP lines.

Competent staff

- The unit has a practice development nurse who facilitated bed-side teaching.
- The unit has implemented the first advanced care practitioner in the region.
- All nursing staff was subject to an annual registration check and were supported to maintain their continuous professional development.
- 80% of the nursing staff had a recognised post registration certificate in critical care nursing.
- 93.18% of people who participated in the Meridian patient survey reported they had confidence in the nurse treating them.
- There was support and guidance in place for newly appointed consultants.
- Staff underwent 360 degree appraisals as part of the revalidation process.
- We reviewed records that demonstrated 90% of staff annual appraisals had been completed. The staff we spoke with confirmed that they had received an annual appraisal.
- The Meridian survey results demonstrated that 97.73% of patients reported the doctors and nurses worked well together.

Critical care

- The NHS staff survey results demonstrate the percentage of staff receiving job-relevant training, learning or development in last 12 months to be within the top 20% of trust in the country.
- There was evidence of high quality and regular teaching and support in the department. Junior doctors told us "I came here because of the quality of the teaching" and "it has a really good reputation for teaching" and a nurse told us "We get very good training and support here".

Seven-day services

- There was access to radiography, radiology, physiotherapists seven days a week.
- Staff told us that getting support from members of the MDT out of hours was consistently available.

Are critical care services caring?

Outstanding ☆

We have judged the critical care service at Frimley to be caring.

The patients we spoke to told us that they were treated with dignity and respect and had all their care needs met by kind and caring staff that went the "extra mile."

Patients and their relatives reported feeling involved in the care planning process and felt they were kept well informed. The patients individual needs were a priority, with staff going over and above expectations to meet preferences, such as a patient who wanted to go to the hospitals 'time garden'. One person told us "This hospital has a very good reputation and we are very lucky to have it". Other comments received described the service as "excellent" and "first class". The critical care unit meridian patient survey results reported 97.73% of patients felt they were treated with dignity and respect. In addition, 99% of patients stated they would recommend the unit to a friend or loved one.

Compassionate care

- We observed patients being treated in a kind, caring and respectful way that promoted their dignity.
- The relatives we spoke with told us that they felt their loves were treated in a kind and compassionate way by staff that "went the extra mile". Family members said that the care in critical care was excellent.
- Patients told us that they were looked after by staff that were "first class, dedicated and kind".
- We noted curtains were pulled around bed spaces for personal interventions and on ward rounds regardless of the conscious state of the patients.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate way.
- Friends and Family data was being collected regularly and being used to improve the service. The friends and family test demonstrated high levels of satisfaction with the care delivered on the critical care unit.
- Data suggested that over 99% of the patients treated at Frimley Park Hospital would recommend the service to a friend or loved one.
- The meridian patient survey results reported 97.73% of patients felt they were treated with dignity and respect.
- Analysis of data from the CQC's Adult Inpatient Survey 2013 overall indicates that the Trust scores within the expected range for all ten areas of questioning.
- Staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet patients wishes. One example included a patient wanting to spend the final stages of their end of life care in the hospitals 'time garden' with relatives and the staff going the extra mile to ensure all the equipment could be transferred.

Patient understanding and involvement

- We saw staff interact with patients in a compassionate and informative way using communications styles that was tailored to patient's individual needs. An example of this was a young patient with complex needs and extreme anxiety. The staff member used good verbal and nonverbal methods of communication that promoted understanding and reduced the anxiety for this patient as well as ensuring their privacy was maintained.
- We saw evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.

Emotional support

- We were told that emotional support was provided by all members of the critical care team routinely.

- The service promoted the use of patient's diaries. This practice assisted patients with reflecting retrospectively on their experience of critical illness and helped those coping with critical care unit post-traumatic stress disorder.
- We witnessed a member of staff breaking some bad news about a patient's condition worsening during the inspection. This was done in a sensitive and compassionate way that allowed the relatives to ask questions about the information they had received.
- Relatives had access to a chaplaincy service covering all major world religions.
- We found evidence of psychological support service provided by a psychologist for all discharged patients.
- We reviewed a set of notes that evidenced a mental health review that addressed a patients anxiety and depression levels. Recommendations were in place to manage the condition.

Are critical care services responsive?

Good

We have judged the service delivered in the critical care unit at Frimley Park Hospital to be responsive.

Patients who used the services received critical care treatment within one hour of referral which exceeds the national target of four hours. However, 50% of patients experienced delayed discharges due to a lack of available beds in ward areas. This did not prevent patients from receiving the care and treatment they required. The trust was also in the process of increasing the number of their level two beds.

The department worked tirelessly to ensure it met the needs of the local people and took their opinions into consideration when trying to improve the service. There was evidence to suggest the service placed a great value on the comments and suggestions received from patients and relatives.

The unit had two relatives' rooms, one with on suite facilities for overnight stays.

We found low levels of complaints and evidence that the service responded appropriately to people's comments and concerns. Staff told us that the service was responsive to any comments or concerns they raised. Patients who were in the unit for a period of more than a week had a meeting with the matron so they could raise any concerns they may have.

Staff working patterns had been extended in order to deliver a more specialist-led service for patients.

Service planning and delivery to meet the needs of local people

- The service had four escalation (stand-by) beds situated in the main recovery area which provided extra capacity during busy times. The staff in this area were dual skilled and had the necessary training to care for patients that required a stay in this area. This meant that the service had the ability to deal with unforeseen emergency admissions and periods of peak activity.
- The unit promoted staff rotation within the PACU and critical care unit area so that staff maintained the skills they needed to look after patients in the escalation area and to enable them provide cover in the unit when required. This meant that in times of severe pressure or a major incident that staff had the skills required to continue to deliver a quality service.
- The location of this area was directly beside the critical care unit which promoted easy access for staff to review clinical parameters and monitor patients' conditions.
- We also saw that the anaesthetic department used a standardised computerised observational tool that promoted continuity when patients moved from theatres or recovery into the critical care unit.
- The unit had two relatives' rooms available. They appeared comfortable and uncluttered with ample refreshment facilities. One of the rooms had a pull out bed and en-suite facilities for relatives who required overnight stays thus promoting a caring environment for patients' loved ones.
- There was an ample supply of information and drinks facilities for relatives in the waiting rooms.
- The unit had recently implemented a booklet that provided all relevant information for patients and relatives. For example it explained aspects of the environment, what the patients and relatives could expect from staff, explanations of uniform colour, information on how to complain about the service provided.
- The service had implemented a bereavement services for relatives as well as an annual memorial services for those who had passed away whilst on the unit.

Critical care

- The unit provided a community outreach service for patients discharged with a tracheostomy. This promoted continuity of specialist advice, promoted safety and reduced hospital readmission for this patient group.

Access and flow

- The unit provided a service with a capacity of 12 beds to a local population of 400,000.
- Proposed admissions to the unit were reviewed by a consultant and outreach staff could make direct referrals. Nurses on the outreach team were able to refer patients directly to the consultant in charge of the critical care unit for admission review.
- Data we reviewed demonstrated that the requirement for critical care beds had been steadily increasing which has led to the national occupancy guidelines being exceeded.
- National guidance suggests that patients who require intensive care treatment should receive it within four hours of referral. We reviewed evidence that demonstrated that patients at Frimley Park received intensive support within one hour of referral.
- Data reviewed for the last 12 months demonstrates a cancelation rate of nil for elective surgery due to lack of critical care beds.
- Patients who were discharged from the unit had a critical care consultant review and their care overseen by the outreach team. This meant that readmission rates to the unit were low, because patients individual care needs were managed effectively after discharge. This level of input provided extra support and advice for the ward staff caring for patients with higher care needs.
- There was a discharge protocol in place to ensure safe discharge pathway for all patients. This included discharge letters, nursing handover and notes, medical handover and informing the outreach team who then reviewed the patient in the ward areas. We found the unit provided an established MDT follow up clinic for patients.
- We noted that 50% of the discharges from the unit were delayed due to the lack of availability of beds on the wards. However, people still received the care they needed in a safe and effective environment despite the pressure on ward beds.
- The unit has a target of less than 10% for out of hours patient discharges (10pm – 7am). Data for the last three months demonstrates that this target was not being achieved.
- Recent audit data shows identifies a need for more level two beds in the hospital to improve efficiently and continued compliance with the national recommendations for unit occupancy which is currently 85%. The unit's occupancy exceeded this between Feb 2013 and Jan 2014. The Trust is in the process of addressing this through a building project that will increase the number of level two beds.

Meeting people's individual needs

- Interpreting services were provided by the trust.
- The care plans we viewed demonstrated that peoples' individual needs were taken into consideration before care was delivered.
- We were told the hospital had a specialist learning-difficulty team that provided patients and staff with support when people with a learning disability were admitted. Staff were able to tell us how supported they felt by the team during a recent admission of a person with a learning disability.
- Patients living with dementia had a "This is me" care plan in place. This is a tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It also enables health and social care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs. The unit had a dementia care champion which demonstrated that best practice for dementia care was being implemented.
- There was a good awareness amongst staff of the delirium that patients experience as a result of their treatment in this environment. Staff told us how they tried to minimise noise and lighting in an attempt to normalise the care environment.
- We found the unit promoted protected sleep times for patients and had implemented use of an 'electronic ear' to facilitate noise level management. The electronic ear monitored the noise levels in the unit and if they exceeded a certain level it would indicate to staff that the levels needed to be addressed immediately and reduced.

- Orthopaedic trauma patients were identified as a vulnerable patient group and their care was delivered by the trauma anaesthetic group who provided support and liaised with the critical care unit to ensure optimum patient placement post-surgery.
- The hospital had a range of clinical nurse specialists that provided support if and when needed.

Learning from complaints and concerns

- We saw evidence that the service learned from concerns and comments. The most recent example of this was concerns about noise levels. The service had reacted by installing the electronic ear to monitor the noise levels and had ear plugs available to patients who require them.
- Documents reviewed demonstrated that complaints made were reviewed, addressed and responded to by the matron of the service.
- Information on how to raise a concern or make a complaint was readily available to patients and relatives. Support was also provided to people who wish to complain from unit staff, matron and the hospital Patient Advice and Liaison Service (PALS). Relatives we spoke to told us if they had to complain, they felt confident they would be listened to and treated with dignity and respect during the process
- Staff openly addressed any concerns or complaints raised in the unit and instantly entered into open discussions with patients and their loved ones. Input was sought from the unit matron as a standard response.
- The unit displayed the number of plaudits and complaints it received every month for relatives and patients to see. It reported four plaudits and no complaints for July 2014.

Are critical care services well-led?

Outstanding ☆

We have judged the critical care unit and PACU departments at Frimley Park to be well-led.

We found an effective governance structure that promoted a high level of staff confidence. Risk registers demonstrated that risks were identified, recorded and actioned appropriately as well as ensuring a transparent audit trail.

The service could demonstrate a clear vision and strategy for the service and the staff we spoke to were able to tell us what that strategy was. Staff felt happy with the level of engagement and felt confident they could discuss any concerns with their leaders with ease and in the confidence they would be listened to.

We identified and witnessed a transparent, inclusive, proactive and selfless culture. This was evident from the hours the consultant and allied professional worked over seven days a week. Nursing and support staff provided flexibility within the department to provide high quality care that met patient's care needs. It was apparent from the conversations we had with staff at all levels that their main focus and priority was patient centred, quality care delivery. We noted staff demonstrated a real passion to deliver the best care they could and embrace any challenges they faced with optimism and a genuine multidisciplinary team spirit.

Vision and strategy for this service

- The vision of the unit was to continue to deliver its services in line with trust values through strong clinical and managerial leadership and rise to the challenges of future care of the critically ill, to continue to embrace new technologies to improve patient outcomes, roll-out the advanced critical care practitioner programme and to improve dementia care in by implementing the best practice in line with the trust vision for 2014.
- We were told that the hospital management recognised a need for more beds available as step down beds to ensure patients who had increased care needs but did not require critical care unit care would be cared for in a more appropriate environment. It would also have an impact on the timeliness on discharges from critical care unit. We noted a renovation programme underway during the inspection that would facilitate the availability of these beds.
- Staff we spoke to were aware of the strategic priorities of the service.

Governance, risk management and quality measurement

- The critical care unit has board level representation and oversight of risks at service meetings.
- The unit has representations at the following meetings: Quality Board, Critical Care Delivery Group, Hospital Infection Control Committee, Clinical Governance Committee (which included an annual presentation),

trust M&M meetings, Resuscitation and Deteriorating Patient Committee, Acute Kidney Injury Working Group and the Trauma Care Delivery Group. This showed the unit were engaged with the governance activity of the trust overall.
- We found information from governance meetings was cascaded to staff via emails, meetings, handover 'hot topics' briefings and lunch time learning sessions.
- We found the service had effective and appropriate systems in place to mitigate risks in infection control, staffing control, staffing, patient outcomes and capacity/ flow.
- The service demonstrated a dedicated focus on understanding and addressing the risks to patient care.

Leadership of service
- We found evidence of strong leadership in the service at local and board level.
- It was clear from our conversations and data we reviewed that staff had confidence in the leadership at all levels. Staff reported feeling very supported by their teams and immediate line managers and the executive team. We asked the staff about their perception on quality of leadership at Frimley and the comments received included "We feel we can escalate concerns to board level if we need to" and "we have confidence we would be listened to", "The CEO really cares" and "our leadership encourages engagement."

Culture within the service
- We found the care and service delivered in the unit showed a strong cohesive team approach to work. It was clear that an open, transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- We found an established multidisciplinary and inclusive culture in the critical care unit and PACU. Staff were encouraged to challenge clinical decisions and empowered to 'speak out' if they had concerns or comments to make.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- During our inspection we noted staff being positive and caring towards patients who used the service. However, we also noted a caring and respectful culture towards each other, their immediate teams and the organisation as a whole.
- Staff expressed pride and commitment to working for Frimley Park Hospital. Administration staff told us they felt valued in their roles and felt very much part of their teams.
- We were told by staff about the 'open door' policy at department and board level. This meant that staff could raise a concern or make comments directly with senior management which demonstrated an open culture within organisation.
- We were also told by staff that Frimley Park Hospital was recognised as having "one of the best cultures to facilitate military/civilian integration".

Public and staff engagement
- Staff told us that they could attend meetings with the chief executive and other members of the senior management team.
- Staff reported feeling involved and consulted about changes in the trust and felt very confident that they would be 'listened to' if they had a suggestion or a concern about the service.
- The relatives we spoke to told us they felt very involved in the care delivered to their loved ones.

Innovation, improvement and sustainability
- The unit had adapted a "best practice approach" to patient management which meant that all patients were assessed daily against a set of interventions that have been shown to improve outcome in the critically ill patients.
- The unit at Frimley Park Hospital was the only regional training unit which has a role as advisor to the Intensive Care Society.
- The critical care unit was actively involved in research and has taken part in three multicentre trials in the last year. The team had presented their findings at The British Association of Critical Care Nurses.
- The Staff acuity tool developed on the unit is being adopted by the regional critical care network and is being rolled out across the trust.

Maternity and family planning

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

Information about the service

Frimley Park Hospital NHS Foundation Trust provides maternity services to approximately 5,500 women in the county of Surrey and Berkshire. Working closely with community service, the hospital has a range of antenatal and post-natal services including early pregnancy diagnostics, out and inpatient antenatal screening and assessment. A triage service enables women to be directed as to the most appropriate support. The labour ward, undergoing refurbishment at the time of inspection has one pool room, separate labour rooms and access to operating theatre for both elective and emergency deliveries. The post-natal ward cares for women and their babies prior to discharge.

We visited all areas of the maternity services and spoke with ten women, four husbands and one visiting relative. We spoke to 27 members of staff across a range of roles and grades, including midwives, doctors, consultant obstetrician's, domestic personnel, midwifery care workers, and members of the management team. We also spoke with one volunteer. We made observations in respect to the provision of care, such as staff interactions, availability of equipment, the environment and safe practices. We reviewed formal arrangements including audit and safety outcome data in order to evaluate the governance systems in place.

Summary of findings

Overall we rated maternity services as good. The maternity department provided safe and effective care in accordance with recommended practices. Outcomes for women using the service were continuously monitored and where improvements were required action was taken. Staff were confident in reporting incidents, knowing these would be reviewed and lessons learned would be shared.

There were occasions where bed flow and capacity interrupted the provision of services to women. This meant that on occasion women were required to have planned induction of labour postponed.

Resources, including equipment and staffing personnel, were sufficient to meet the needs of women, although the midwife-to-women in labour ratio was lower than the recommended levels. Staff received the necessary training and assessments of their competencies so they could respond to women's treatment and care needs. Midwives had supervision of their practice and staff had opportunities to get feedback on their performance as well as developmental opportunities.

The individual needs of women were taken into account in planning the level of support throughout their pregnancy. Feedback from women and their respective family was positive about the service they received, the level of care and compassion, respect for their dignity and privacy.

Maternity and family planning

Staff said that there were clear lines of accountability within the maternity department and leadership was a positive aspect of the working environment and culture. Staff were clear about their roles and responsibilities and had a commitment to working in a manner that reflected the values and ethos of the trust.

Are maternity and family planning services safe?

Good

The maternity department had effective systems in place for reporting, investigating and acting on adverse events. Information was routinely collected and reviewed around standards of safety and shared with staff and the public.

The environment and equipment used in the delivery of women and babies care was suitably clean and ready for use. Staff followed safety guidance for infection prevention and control. Medicines were managed safely.

Records related to the care of each women were detailed enough to identify their individual needs and to inform staff of any risk and how these were to be managed. Care records were completed at regular intervals and contained evidence that the consent of women was sought as required and safety checks took place. Women reported feeling safe and confident in the skills of midwives and we found staff had received mandatory training in areas relevant to the safety of women, such as safeguarding, resuscitation, emergency procedures.

The midwife to women ratio was higher than recommendations and staff reported at times this put them under pressure. Medical staffing arrangements were in place, ensuring relevant practical expertise and guidance was available to midwives and women during all stages of the maternity journey.

Incidents

- There had been one reported never event in the maternity service, which was a retained swab. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.
- Staff who spoke with us demonstrated their awareness and use of the incident reporting system which was available in each clinical area. Reported incidents ranged from issues around capacity through to more complex matters such as post-delivery bleeding or shoulder dystocia. (Shoulder dystocia is a rare

emergency that can happen during the end of the second stage of labour. Shoulder dystocia happens when the baby's head has been born, but one of the shoulders becomes stuck).

- We found that incident review meetings had been held regularly, during which a full review of incidents took place. Medical staff also reported they were learning from the process of root cause analysis reviews of events. The maternity risk and clinical governance newsletter circulated to staff demonstrated evidence of discussion around learning from reviews, such as care of cold babies as well as feedback from the trust patient safety committee.
- Doctors reported to us that CTG meetings had been very well run with consultants summarising cases and discussion of learning points arising from these.

Serious Incidents

- Between the period 1 November 2013 and 31 May 2014 the trust reported one serious incident related to maternity. We reviewed summary notes of a review in relation to a recent adverse event resulting in an unplanned maternal transfer to ITU and subsequent hysterectomy following ruptured uterus and intrauterine death. We saw the Corporate Governance Group (CGG) report for this incident and noted the review included recommendations and actions, demonstrating to us a culture of no blame and learning from such incidents.
- There were quarterly perinatal mortality reviews and risks also fed into the mortality meetings.

Safety Thermometer

- Frimley Park maternity unit was participating in the pilot safety thermometer specific to hospital and community maternity care. Data was being submitted on the last Wednesday of each month in respect to the following areas: Perineal and or abdominal trauma; Post-partum haemorrhage, infection, separation from baby and psychological safety, Apgar scores of less than seven at five minutes and admissions to Neonatal unit. We were able to review summary results for May 2014, which included comparisons with other similar participating organisations and trends in the local results.
- The maternity service also participated in the NHS safety thermometer for the trust and collected information in respect to patient falls, catheters and urinary tract infections, and pressure sores for example. Results of the safety thermometer were displayed on ward areas and we noted that there had not been any reported incidents of these kinds since September 2013, achieving 100% harm free care.

Cleanliness, infection control and hygiene

- We made observations in all areas of the hospital which provided maternity services, including the labour theatre. We found the standard of cleanliness to be good, particularly in the immediate areas in which women were receiving treatment and care. There was evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning. Women who spoke with us told us they were satisfied with the level of cleanliness, including the toilets and shower facilities.
- Domestic staff had access to the recommended national colour coded cleaning equipment and we observed the use of such items in the course of their cleaning duties.
- Information in respect to hand hygiene audits were displayed on ward areas, as was information about infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.diff). There were no reported incidents of either of these in the maternity areas visited.
- Staff informed us there were lead midwives for infection control in each area. We saw staff were required to attend infection prevention and control training as a mandatory subject and 98.7% of midwifery staff had done so up to the end of March 2014.
- Staff were noted to be following the hospital dress code policy to be bare below the elbow. There was access to decontaminate hand gels on entry to all areas and also at the point of care. Staff had good access to and were seen using hand washing and drying facilities between the delivery of care activities. Staff also had access to and were seen using personal protective equipment, such as gloves and aprons.
- We observed staff to be following best practice infection control principles in relation to management of waste, including sharps items, contaminated waste and laundry. In addition we saw information which reported high levels of compliance with infection control practices such as hand hygiene.

Environment and equipment

- Resuscitation equipment was readily available in all clinical areas and was clean and checked for

functionality. Emergency equipment was available for treating adverse events, such as post-partum haemorrhage. (This is excessive bleeding after the delivery of the baby).

- We saw and midwives confirmed with us cardiotocography (CTG) equipment was available to enable them to monitor the foetal heart rate during second stage of labour. Other technical equipment including 16 resuscitaire's were available in delivery rooms. The birthing pool was contained within a separate room and there was guidance and checking procedures related to the cleaning and preparation of this for staff to adhere to.
- There was phased work in progress to develop the labour ward, which was being managed in a way to cause the least disruption to women using the service. One woman did tell us they were unable to shower after the delivery of their baby as no facilities were available at the time. A number of delivery rooms had been completed and these provided en-suite facilities. Work was continuing with the intention of providing a midwifery led unit.

Medicines

- There were effective arrangements in place for storing medicines, including controlled drugs and refrigerated items. Care records detailed all medicines prescribed, the route to be given and frequency. We saw staff signed the record when medicines had been taken or administered.
- Women were able to self-medicate after the delivery of their baby, subject to assessment and consent.
- We were advised there was representatives from the midwifery service on the safer medicines committee and no medicine related harm events had occurred up to the time of our inspection. The clinical governance newsletter was used to inform midwives and medical staff of changes related to medicines and we saw information shared with staff around medical treatment using medications.

Records

- Women who used the maternity services had been provided with their own set of care records, which included community midwifery information and records of antenatal checks, scans and screening tests, such as for Downs Syndrome. These records were brought into the hospital on admission or when attending clinics or the assessment unit, where they were then updated accordingly.
- The hospital also retained a separate set of records and we saw information recorded in respect to assessment and provision of treatment and care. For example, referral to relevant expertise, including to the gestational diabetes consultant obstetrician in the antenatal period. We saw records of the labour and delivery method along with interventions such as pain relief, all of which provided a clear picture of staff support and treatment delivery.
- We reviewed five sets of care records of women who had delivered their babies. We did not identify the preferred name of the women on any of these. We saw the name of the midwife leading on the women's care had been recorded. All records included essential information such as their demographics and where the women had written their own birthing plan, this was visible too.
- Where caesarean section had been 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 had been conducted and identified any potential or actual risks, including for example, venous thromboembolism (This is a blood clot in the vein). We saw too that pain assessments had been carried out and acted upon. In addition we saw evidence of the involvement of the physiotherapy team with respect to post-delivery exercises.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women who spoke with us confirmed they had been given sufficient information to help in making decisions and choices about their care and the delivery of their babies. One woman told us they had been given" lots of information and advice and staff have listened to me." They added, "I made the choice to have a normal delivery and I had exactly what I wanted."
- Consent forms were noted in care records of women who had undergone caesarean section. Women had also formally consented to screening tests and to self-medicate, with signed forms present in a number of the records reviewed. We noted verbal consent had been sought for vaginal examination during the assessment of labour and this was recorded.

- Staff had a good understanding of mental capacity and advised us in respect to women with special needs, the community midwife made arrangements via the needs co-ordinator and their care plan was arranged accordingly.

Safeguarding

- We were told there was a dedicated Lead Nurse for Safeguarding Vulnerable Adults. Midwifery staff confirmed they were notified of any potential safeguarding concerns through a vulnerable adult 'green' form. The green form was sent to the safeguarding lead by the midwife, either in the community or hospital based and a copy was put into the hospital records.
- Staff who spoke with us had a good understanding of the need to ensure vulnerable people were safeguarded and understood their responsibilities for identifying and reporting any concerns. Safeguarding training was a mandatory subject for staff and we saw from training records 98.7% of midwifery staff had received this training up to the end of March 2014.

Mandatory training

- Medical staff who spoke with us commented favourably on the provision of training. One comment made to us was, "best year of training here." Teaching was said by this doctor to be organised and held on a Friday. They were learning laparoscopic and surgical skills and commented on being disappointed to be leaving later in the year.
- We had discussion with doctors where they described having multi-disciplinary 'skills and drills' training. Mandatory training was also required to be completed and some of this was provided at induction and other as e-learning. Reminders were said to be sent out and if they still did not complete, the medical director would get involved.
- Midwifery staff including students reported having mandatory training in areas such as emergencies, safeguarding, mental health and mentorship. We saw training records which indicated a high level of compliance with courses that required attendance, such as risk management and adult resuscitation. However, we noted where staff were required to complete an e-learning element of the training; the compliance with this was less satisfactory. We spoke with the head of midwifery regarding this and were informed reminders were sent to staff. A second reminder would result in the line manager speaking directly with the individual.
- The head of maternity advised us an education and training report was provided to the Obstetrics and Gynaecology clinical governance meeting. The report identified key issues, such as training attendance and monitoring of this.

Management of deteriorating patients

- Midwifery staff used an early warning assessment tool known as the Maternity Early Obstetric Warning System (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond to additional medical support if required. The records we reviewed contained completed MEOWS tools for women who had been identified as at risk.
- There were arrangements in place to ensure checks were made prior to during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation (WHO) surgical safety checklist in operating theatres. We reviewed care records for women who had undergone caesarean section and saw all parts of WHO records present had been completed.

Midwifery staffing

- For the financial year 2013/14 the birth to midwife was funded to be 1:33, with a 90/10 split between qualified midwives and maternity care assistants. Quality clinical outcomes shown to us indicated that in May 2014 the ratio of women to midwife was 1:34.5, with a year to date as of the end of May 2014 achieving a ratio of 1:34. The national recommendations for caring for expectant women are 1:28.
- In June 2014 the head of midwifery presented guidance on staffing levels for all care settings related to obstetrics and midwifery and presented a paper to the board to improve staffing levels. There was approval and funding for a ratio of 1:31 birth to midwife ratio at the time of the inspection.
- We saw information which highlighted the required staffing levels in each department to cover days and night shifts or working hours for departments such as antenatal clinics and saw staff rotas to support these levels. There were 159.45 whole time equivalent midwives ranging from band five to band eight c and

band two and three midwifery care assistants. There were no reported midwife vacancies at the time of our inspection. The skill mix in maternity services was 90% trained and 10% untrained.

- The ratio of staff was said to work for the level of general activity, although in our discussion with midwives we were told there were times where extra hands were required and that when activity peaked the supervisors of midwives could be called in to help. Many of the midwives were part time but bank staff were said to be available at times of sickness or other absences. Agency staff were not used in the maternity areas.
- The monthly compliance report for staffing in the maternity wards was noted to be published on the Trust's website for May and June 2014.
- Midwifery staff had shifts of twelve hours duration and these were described as "challenging" by some staff. A handover took place between outgoing and oncoming staff. We observed this taking place between day and night staff and heard that all staff were given an overview of the women on the respective unit and their progress or needs by the person in charge. Midwifery and support staff then went to the person who was looking after each assigned women and received a more detailed report.
- The trust used the Intrapartum 'Birthrate plus' monitoring tool four hourly on the labour ward. This enabled the midwives to assess their "real time" workload in the delivery suite arising from the numbers of women needing care, and their condition on admission and during the processes of labour and delivery. The trust reported the percentage of women given 1:1 care from a midwife whilst in labour was generally good. They did highlight the annual percentage rate for the period June 2013 to May 2014 as slightly under the expected trust target of 95%.
- Obstetric theatre staffing was managed by the head of nursing for theatres. Midwifery staff did not undertake theatre duties for elective or emergency caesarean sections but did however provide support to the baby after delivery.

Medical staffing

- Quality clinical outcomes data reviewed by us indicated 128 weekly hours of dedicated cover from consultants' presence on the labour ward for April and May 2014, with the year to date at that time of 128 hours. A report by the head of midwifery in June 2014 outlined the consultant staffing levels in maternity services as 1.5 whole time equivalent (WTE) consultant obstetricians and gynaecologists, one of whom was a locum, three clinical fellow and one trust doctor. The report indicated there was 132 hours of consultant presence for the labour wad. The service also had eight WTE registrars and one trust doctor providing cover to the labour ward.
- There were 15 consultant anaesthetists, one of whom was nominated consultant in charge of obstetric anaesthesia. Sessional theatre cover was being provided between the hours of 07:00 and 19:00 Monday to Friday, with out of hours on call cover.

Major incident awareness and training

- The trust had in place business continuity action cards to support the emergency planning and preparedness policy, which the staff in maternity were aware of.

Are maternity and family planning services effective?

Good

Staff working in each area of the maternity service had access to professional guidance to inform their practice. Standards to support effectiveness had been put in place with regard to staffing levels, roles, the facilities and equipment. Midwives had been trained to deliver their roles effectively, had been supervised and supported to maintain their competencies and professional development. Multi-disciplinary working was good between hospital and community services and support from allied health professionals and specialist expertise was available to women using the maternity services.

Most women we spoke with reported having their pain managed very well and that staff made every effort to resolve pain by alternative medicines or changing positioning. The nutritional and dietary needs of women were being met and positive comments were shared with us about the choice and amount of food provided. Women were supported to feed their babies as they preferred to do.

The trust participated in the collection of information related to the outcomes for women who used the service through the quality and performance dashboard. Audits were also carried out in order to assess and evaluate effectiveness of care provision.

Maternity and family planning

Evidence-based care and treatment

- There was evidence available to demonstrate women using the services of the hospital were receiving care in line with National Institute for Health Care Excellence (NICE) quality standards 22, related to routine antenatal care, including screening tests for complications of pregnancy. In addition NICE guidance 32 was being adhered to in regard to caesarean section and guidance 37 for post-natal care.
- Care was seen to be provided in line with Royal College Obstetricians and Gynaecologists (RCOG) guidelines including Safer Childbirth: minimum standards for the organisation and delivery of care in labour. For example, we saw evidence of the arrangements around staffing levels, roles, facilities and equipment. In addition the arrangements for training and development, continuous professional practice supported to principles underpinning this guidance.
- Midwives reported using RCOG 'green top' guidelines to inform their practice. An example of such a guideline shown to us was in respect to maternal collapse.
- We saw numerous policies and procedures available to staff which informed their practice and were followed during the provision of care. For example; Epidural analgesia in labour, management of shoulder dystocia and management of uterine prolapse.
- We reviewed information related to various audits, including the obesity antenatal care and foetal monitoring audits which were carried out in April 2014. Audit of non-elective caesarean section between April and March 2014 made recommendations around completion of documentation, including delays and escalating concerns when activity was high or difficulties experienced.

Pain relief

- Women's hand held care records contained detailed information about pain relief during labour to help them in the decision making process.
- Women who spoke with us told us and we confirmed in their care records reviewed they had been offered and provided with a choice of pain relief. This included for example, delivery under Epidural procedural, Entonox, or with controlled medicines such as Pethadine. Pain relief medicines were prescribed and signed for as given, providing a record of frequency of administration.
- The maternity service had a dedicated obstetric anaesthetist available to support the pain management needs of women in labour. Staff had access to medical advice around pain management, in addition they had access to policies to guide them, for example; Epidural analgesia in labour.
- We noted in one case where pain relief did not provide the required level of cover, staff ensured additional or alternative medicines were fully considered and used as appropriate.
- A review of care records and discussion with women demonstrated pain levels had been assessed by midwifery staff. Women told us they had been given pain relief as needed. Two women explained they were self-medicating with regards to pain relief.

Nutrition and hydration

- A food service was provided to women using the maternity in-patient facilities. This included provision of cultural and religious specific menus, such as Halal and Asian vegetarian. In addition medical related diets could be catered for, such as nut allergies or gluten, wheat and dairy free or diabetic. We noted out of hours food provision was via a vending machine, although sandwiches and toast were provided at night on the labour ward.
- We asked women who had delivered their babies about the arrangements for food provision. Comments made to us included; "food is fine, edible with lots of choice." Another said there is a "good choice of hot and cold and plenty" and went on to say staff made them a sandwich in the night and "we can help ourselves to drinks."
- We saw that where women had needed intravenous fluids to support their treatment staff had followed a prescription for this and recorded fluid intake and output as part of the monitoring process.
- A midwife led weight management clinic took place on a weekly basis. The obesity care pathway was seen to be designed around the achievement of healthy outcomes for the expectant woman and their baby, as was the diabetes care pathway.
- Women had been supported to feed their babies in their preferred method. Staff were able to provide additional support to those choosing to breast feed, including midwifery care workers who had been trained to help in this area. Verbal information was supplemented by written leaflets and we saw the policy titled 'Parents guide to the maternity services breast feeding', which contained additional information.

Maternity and family planning

Patient outcomes

- There were 465 births in May 2014 and year to date 909, which represented an increase of 9% on the previous year. The percentage of caesarean sections was 24.9% for March 2014. Reviews had taken place of all cases which demonstrated that all were clinically necessary. The overall yearly figure was 24.3% against a target of 23%. Information reviewed by us indicated from January to November 2013 Frimley Park Hospital NHS Foundation Trust performed better than the England average in terms of normal deliveries (spontaneous vertex), 63.4% compared to 60.7%.
- The trust scored similar to what was expected in regard to alerts for elective and emergency caesarean sections between the period of April 2012 and January 2014. An audit of non-elective caesarean sections for the period April 2013 to March 2014 indicated 667 procedures had taken place within the three categories of urgency in delivery time, an increase of 44 or 7% on the previous year. The overall achievement of the expected time targets was 77.1%.
- Staff advised us that on occasion there were maternity outliers (pregnant women receiving care on other non-maternity wards). Usually these women were admitted for clinical reasons that affected them rather than the baby. Staff said once they were aware of the location of these women they would ensure that the Maternity Early Obstetric Warning System (MEOWS) assessment tool was provided to ward staff to use.
- Information related to outcomes for women using the service was collected as part of the maternity performance and quality dashboard. We reviewed data related to activity, including for example the number of spontaneous vaginal deliveries with a goal set as greater than 70% of deliveries. The outcome for June 2014 was this had been achieved in 87% of the deliveries that month and year to date for 64.7%.
- Operative vaginal deliveries using Ventouse or forceps had a target of equal or less than 15%. In June 2014 the results indicated 8.1% and year to date 10.6%.
- The goal for elective caesarean section was set at 10%, with a score achieved in June 2014 of 8.7% and year to date 10.2%.
- A red score was noted on the dashboard in regard to the expected target of 75% for successful vaginal birth after caesarean section (VBAC), with an outcome score of 89% for June 2014 and year to date, 81%.
- We saw information that had been collected and reviewed in regard to 3rd and 4th degree tares which occurred between April 2013 and March 2014. The incidence of obstetric and anal sphincter injuries (OASIS) had been monitored through the monthly dashboard and was reviewed at the risk management group. From this we could see what staff were doing well and what needed to be improved and an action plan was agreed.
- The trust was participating in national audits around the following: Diabetes in pregnancy and HIV in pregnancy. Information was also been collected and contributed towards the normalising birth programme with South East Coast and stillbirth reviews with the Thames Valley strategic clinical network. Each still birth case was fully reviewed in the risk management group then again once post mortem results were available. In order to identify any lessons that could be learnt.
- The trust used the 11 Royal College of Obstetricians and Gynaecologists (RCOG) indicators set out in the Patterns of Maternity Care in English NHS Hospitals to help develop and improve pathways available to women.
- Maternity readmission rates were similar to expected for the period of April 2012 and January 2014.
- The risk management report for January 2014 to March 2014 indicated one admission to the neonatal unit for ongoing support and prematurity. Subsequent investigation and review took place following the baby's death. The serious incident was reviewed by the corporate governance committee in May 2014 and recommendations from this disseminated.

Competent staff

- All women and their partners who were present during our discussion confirmed they were satisfied with the skills and abilities of the midwifery staff. One woman told us "the midwife did the suturing." Another new mother said the midwife had been "brilliant." Other comments about the midwives included; "very good, very professional throughout." All said they would recommend the maternity services.
- Midwives had induction work books with associated training around for example areas of medicines management, record keeping, equality and diversity and infant feeding. In addition various levels of competencies to be achieved which were associated on their grade and expected level of responsibility. For example, newly qualified midwives went through a

period of preceptorship, during which they were assessed on various aspects of their skills. We saw competency was assessed for key areas, including; monitoring progress in normal pregnancy, provision of Intrapartum care and participation in the care of women with high risk pregnancy. Other more specific skill related competencies included, the administration of injectable medicines and perineal repair.

- Practice development was taking place for midwives and we saw evidence to indicate that various areas of skills and competence updates had been made available, including a Perineal repair workshop for suturing. We were informed that maternity support workers were 'up-skilling' through a specific pathway of in-house training over a six month period. Support workers confirmed this arrangement was taking place. Maternity support worker update days in for example, breast feeding, blood transfusion and neonatal resuscitation were also being held.
- The Local Supervising Authority (LSA) annual report to the Nursing and Midwifery Council (NMC) for 2012/13 indicated that 98% of midwifery staff had a supervisory review during the period 2012/13. We also reviewed the draft report following the LSA audit visit which took place in March 2014. This reported the achievement of the standards set by the NMC and the LSA in regard to supervision of midwives for 2013/14. The maternity service had 15 Supervisors of Midwives (SoMS), with an average number of supervisees of 1:15 and had completed 98% of the required annual reviews. This was reported as an excellent achievement by the LSA.
- Antenatal and new-born screening education audit and indicators were said to be submitted on a quarterly basis to the UK national screening committee. The maternity service had 35 midwives trained to undertake new-born examinations, which meant that 95% of new-born examinations were being carried out in either the hospital or community.

Multidisciplinary working

- Staff told us there was good multi-disciplinary working with a guidelines group and labour forum made up of representation from a range of disciplines.
- External MDT working included specialist foetal medicine working in collaboration with St Georges.
- We found there were effective working relationships with the hospital and community maternity team. A community advice line was set up in January 2014 to provide support to pregnant women on weekdays between the hours of 8am and 4pm. Information was recorded in a book and also in women's' notes if necessary from the communications. A review of this service indicated it had improved triage and reduced the number of unnecessary referrals. There were monthly community team leader meetings and daily community communications taking place which helped the service to work well across the hospital and community.
- Staff confirmed in their discussions with us that there was access to medical support, in addition to expertise in epilepsy, diabetes and weight management.

Seven-day services

- We saw there was provision for out of hours medical cover including weekend and nights arranged as follows; Monday to Thursday between the hours of 20:30 and 08:30 am on site availability. Friday 20:30 hours through to Monday 08:30 cover was via the on-call system.
- We were told by midwifery staff pregnant women arriving via A&E may be able to be scanned on an ad-hoc basis during the night or at weekends, or they would be asked to return on the Monday to the scanning department held in the antenatal outpatient area.
- The maternity services were supported by having access to physiotherapists, occupational therapists and pharmacy.

Are maternity and family planning services caring?

Good

Overwhelmingly we received feedback which indicated to us the caring and compassionate approach of staff. Women reported being treated with respect and dignity and having their privacy respected as far as possible. Information was said to be provided in ways that could be understood and women felt involved in making informed decisions about their own care and the delivery arrangements.

Staff took into account the individual needs of women and their respective partners and ensured appropriate support was provided to them.

Maternity and family planning

Compassionate care

- We spoke with nine women post-delivery and one woman attending the antenatal clinic about their experiences, four partners and a visiting relative. Comments made were favourable from the women and their partners and included for example; "I have had a good service. My husband was present and staff looked after his needs." They added, "The midwife explained each stage of the labour and I knew exactly what was happening." Another woman said in respect to staff, "Genuinely nice, caring, friendly and approachable. This person's husband told us, "staff were compassionate." The relative of a new mother commented on the lack of perceived speed in helping to support the baby when it didn't feed well after delivery.
- Frimley Park Hospital participates in the Friends and Family Test, which is a government initiative focused on improving patient care. Friends and Family test results for May 2014 indicated that 527 respondents were extremely likely to recommend the maternity department. Year to date figures up to the end of May 2014 indicated that 1430 respondents were extremely likely to recommend the hospital for maternity care.

Patient understanding and involvement

- Women using the maternity services at Frimley Park were provided with a range of information in different formats. For example, they were provided with a leaflet titled 'Your postnatal maternity guide 2013-2014'. Women who spoke with us confirmed they had been given lots of information about the maternity services and the arrangements around the delivery of their babies. One woman said, "I was having a planned section and knew what was happening. I knew that the babies were going to special care baby unit." They added, "I have had lots of information" and in regard to the progress of the babies from the neonatologist rounds "he is very nice and involves me." Partners who spoke with us said they felt involved also.
- We saw the hand held notes retained by each expectant woman contained very detailed information around such as areas as, teaching and midwifery supervision, consent, care of the baby during pregnancy and monitoring the baby's heartbeat during labour and after care. This included details about vitamin K and Jaundice.
- A range of information was also made available to women as confirmed by our discussions. This included guidance about post-natal exercises, bottle feeding and a parent's guide to the maternity services breast feeding policy. We saw other information available on the hospital internet and in leaflet form, such as guidance on reducing the risk of cot death.
- Where women had received midwifery led deliveries we saw the name of the midwife recorded. We saw also that the name of the midwife was recorded in records which related to caesarean section deliveries.

Emotional support

- People using the maternity services could access clinical nurse specialists for the following aspects of care: Antenatal screening, Diabetes and infant feeding.
- We saw that where a woman had previous history of anxiety or depression this was recorded in the care records. We did not see any information to indicate if any formal assessment took place in regard to these emotional needs. We noted on the trust website consultants and specialists in psychological medicine were available to provide psychological and liaison psychiatry services to teams in all specialties at Frimley Park Hospital.
- We did not find any information to assure us of any availability of counselling services. However we were told by staff about the arrangements for supporting individuals who were bereaved as a result of their baby's death. Three midwives had particular interest in this area and they were closely involved in supporting bereaved parents at the time and over subsequent weeks and months. We saw information which informed us an annual remembrance service was arranged by the staff and midwifery staff attended this, providing support and care as required.
- A designated room was provided for the care and support of women and their respective partners to be cared for during and after the loss of their baby. This was noted to be away from the main ward area to reduce distress and enable more direct support.

CQC Survey of Women's Experiences of Maternity Services 2013 – Labour and Birth Data

- To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to rate their experiences. Women were eligible for the survey if they had a live birth during February 2013, were aged 16 years or older and gave

birth in a hospital, birth centre, maternity unit or at home. We were able to compare responses on labour and birth from all 137 trusts that took part in the survey, since we knew the women were referring to the trust from which they were sampled. For Frimley Park Hospital we found the experiences reported as follows: Labour and birth was better than expected and it was similar to expected with regards to staff during labour, birth and care in hospital after birth.

Are maternity and family planning services responsive?

Good

There were occasions of capacity issues related to fluctuation of workloads and winter pressures. This had resulted in cancellation of labour inductions and delayed transfer and admissions to the labour ward, as well as delays to theatre. The system for managing the bed flow was informal and could be improved to the benefit of staff and people using the service.

The maternity facilities were set up in a manner which enabled staff to be responsive to the needs of women and their families. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway. Where women had additional healthcare related needs there was access to specialist support and expertise and specific care pathways. A translation service was available and a number of staff had been trained to provide Nepalese translation in response to the needs of this local community.

People using the service could raise a concern and be confident this would be investigated and responded to. Formal complaints were dealt with as per the hospital policy. Information about how to contact Patient Advise and Liaison Service (PALS) was readily available.

Service planning and delivery to meet the needs of local people

- We spoke with the head of maternity in the absence of the community matron about feedback we had received concerning the lack of continuity of care. We were advised there were 12 teams of community midwives, each having between three and six midwives. Four midwives were on call at night covering home births and there was a buddy system to cover days off. A service level agreement was in place for community services under the provision of Hampshire commissioners.
- The trust had a women's and children's services five year strategy, referred to as 'project 6000', which outlined a five year strategy for supporting the increase in services from 4000 to 6000 births.
- The unit were in the process of building a Midwifery Led Unit (MLU) to meet the needs of low risk women, which was co-located to the delivery suite. This provision of MLU onsite was in response to women being involved in the provision of services and planning, which fed into the overall strategy. The MLU was being completed at the time of our inspection.

Access and flow

- The early pregnancy diagnostic unit (EPDU) and antenatal clinics were taking place in the outpatient area which was also dealing with gynaecology patients. We asked staff how they respected the sensitivity of women who may be attending the service for infertility issues. Midwifery staff told us they would advise the attending woman to let the main reception know they had arrived and they would then be met and brought to the right area without having to go through the main waiting room. In addition baby adverts were not being shown on the information screen at times when infertility clinics were taking place.
- The EPDU was accessible during weekday hours and on Saturday up to 3pm. Four scan clinics were taking place each working day. Women could self-refer for a scan, be referred by the GP or community midwife.
- Pregnant women were booked for their delivery by the community midwife directly using an on-line system. Decisions about the most appropriate and safe leadership of each woman's care was made at the time of the hospital antenatal visit.
- The maternity services included a triage area consisting of two well-equipped and newly refurbished rooms. We were told a midwife was on duty 24/7 for this service. Women could access this service and be confident that they would be assessed and action taken as required. This may have meant being sent home or admitted to the assessment ward or direct to labour unit. Women could also access a day assessment unit, which was located on the antenatal ward.

- A recently established labour ward advice line was available to women. This was run by the community midwives on a rotational basis.
- The flow of women through the various maternity areas was managed by the labour ward co-ordinator, who was said to have a responsibility for contacting the antenatal ward to identify how many women were awaiting induction of labour. They also contacted the post-natal ward to let them know when a discharge was needed. In addition they had to liaise with the special care baby unit to check cot capacity. There was no electronic visual bed management system available to provide at 'a glance' information to staff working in these areas, or that could be updated by staff on a continuous basis to assist in flow.
- We were made aware that there were occasions of capacity issues related to fluctuation of workloads and winter pressures. This had resulted in cancellation of labour inductions and delayed transfer and admissions to the labour ward, as well as delays to theatre. In our discussion with the labour ward coordinator we found there was a process in place which could benefit from improvement around a formal protocol for managing capacity and pregnant women who were 'outlying' on other non-maternity wards as a result of other medical problems. A paper system was in use to record the location of women, which included the co-ordinator writing people's names on a form in pencil and changing them as they moved through the various areas of labour ward and post-natal. Outliers were also recorded in a book and checked on each day by telephone call and then erasing these names once they were discharged. There was no clear protocol for following up on encountered problems.
- The labour ward was part way through refurbishment and consisted of 13 birthing rooms and one pool room. There was access to equipment to assist in birthing, such as bean bags, birthing balls and floor mats.
- An electronic booking system was used to show at a glance what was booked for each theatre. A dedicated obstetric theatre was accessible in close proximity to the labour ward within the main theatre complex. A second dedicated theatre for elective caesarean section lists was operational most mornings. If additional theatre was required, this was said to be arranged as available and a theatre team "created as necessary."
- The post-natal ward had 31 beds, including seven single rooms and a side room designed to facilitate disability access. The hospital had two four bedded bays on the post-natal ward allocated for transitional care. This enabled mothers to stay with their baby's when they required additional care and support due to prematurity. Where continuous medical care was required babies were cared for in the special care baby unit (SCBU) or transferred to an external neonatal intensive care unit.
- The head of midwifery advised us 100% of women were being seen in labour by a midwife at 30 minutes, although this information was not formally collected. All women were seen on arrival to the labour ward by a midwife, meaning that all women had an appropriate assessment.
- Information was not collected in relation to the percentage of women in labour who were seen by a consultant within an hour of request. This was because not all women need to be seen by a consultant. However, where a midwife requested a medical review all women were said to be seen within the hour by a medical practitioner, normally a registrar first and then escalated to consultant if required. We were informed that when registrars were busy and not going to be available for a period of time the midwife escalated the request directly to the consultant.
- At the time of our inspection we were advised the percentage of women seen by ten weeks of pregnancy for their booking was 61.60% and the percentage of women seen by 12+6 weeks (which was the target) was 93%.

Meeting people's individual needs

- Midwifery staff working in the early pregnancy diagnostic unit and antenatal clinic told us the outpatient service had been improved for women by the development of specific care pathways and protocols. This included for example pathways for treatment of women who had Hyperemesis (excessive nausea and vomiting), diabetics and those women who were at greater risk as a result of obesity. We saw examples of these treatment plans in use.
- In addition to information provided to us by midwifery staff we saw there was a criteria for referral of women to consultant led care. This included for example women who had pre-existing cardiac disease, diabetes and previous foetal abnormalities. Referrals were also made to the diabetic midwife as needed and dieticians were attached to diabetic clinical held two days per week.

Complex needs such as those associated with Cystic Fibrosis were said to be managed through direct links to specialist clinic and expertise. These arrangements meant women received the most appropriate care for their individual needs.

- We were advised there was a lead midwife for learning disabilities and those who had mental health needs and the care of women with mental health needs followed a specific pathway.
- We were told by staff the pre-dominant population using the service was that of white Caucasians and a local Nepalese community, who we were told spoke English. A booklet was available to down load titled 'Your Guide to Choosing the Right NHS Service across Farnborough and Aldershot'. We noted that this did not contain anything specific to maternity services.
- We saw information presented in board minutes which indicated Language line was available for translation services In addition external providers were indicated as being used for interpretation and there were 17 Nepalese staff trained to level four medical interpreting.
- There was one labour room designed to facilitate wheelchair access, with level access to shower facilities.

Learning from complaints and concerns

- Information was readily available in clinical areas to explain to people how they could raise a concern or make a complaint.
- Letters were written to women who had difficult caesarean sections and would require one in the future. Debriefs were also offered to women who may wish to have more understanding of events related to the delivery and the situation. Sessions for this were held on a weekly basis. We heard from one woman who spoke with us on the post-natal ward how they had been invited to have a follow up discussion regarding some aspects of the delivery of their baby. Both the woman and her husband indicated they welcomed this opportunity, although they were not complaining about the service. We saw in records reviewed information which indicated that follow up discussion in relation to the persons' care had been arranged.

Are maternity and family planning services well-led?

Good

Staff were extremely positive about working at the hospital and being part of a team who understood and shared a commitment to the trust's values. Staff reported having very good leadership and of feeling involved and valued. There was a level of confidence in reporting events which may have resulted in poorer outcomes for women using the service and that these would be investigated and any learning shared accordingly.

There were well-led arrangements in place for assessing and monitoring the quality of the service. Information was shared in an open and transparent way to staff, the trust board and stakeholders. Staff and the public were encouraged to be involved in future developments of the trust.

Vision and strategy for this service

- We spoke to a range of staff all of whom were very aware of the trusts vision. Staff had the visions printed on the reverse of their name badges and also they were further reinforced by the printing of them on the bottom of emails.
- The trust had a women's and children's services five year strategy, referred to as 'project 6000', which had been presented to the board of directors on 3rd of February 2012. This outlined a five year strategy for supporting the increase in services from 4000 to 6000 births. In order to achieve this, the strategy highlighted the need to increase consultant cover to 168 hours per week and a midwifery ratio from 1:33 to 1:31, as well as environmental development to support the expanding service. Staff who spoke with us were aware of the strategy and the vision underpinning it, this being, to be the best they can possibly be through the provision of integrated services.
- A MLU was being completed at the time of the inspection, which provided a less 'medical' environment for women who were low risk and formed part of the overall strategy.
- A consultant told us the longer term strategy was looking towards the potential merger and acquisition of a local service and around being able to respond to the needs of an increasing capacity of service users.

Maternity and family planning

Governance, risk management and quality measurement

- There were various arrangements in place for assessing and monitoring the quality of services provided. We reviewed the local risk register for the period 2014-2015. The risk register underpinned the Corporate Governance Group (CGG) functionality. This included identifying and understanding the most significant risks, agreeing acceptable levels of risk and approval of actions to mitigate these and to receive assurances that actions taken to manage risks were managed appropriately. We noted the risk register also supported the board objectives, including the improvement of quality and efficiency. Risks identified had been rated using a red, amber and green scheme. The increasing possibility of closing the labour ward was one such risk attributed to the refurbishment programme of the labour ward. This had been rated as amber with actions described including the use of side rooms for women's care.
- Obstetric and midwifery risk management reports were provided for each quarter and the quality committee was responsible for reviewing risk management and patient safety reports. We reviewed the quarterly report for January to March 2014 and saw this included in-depth information around for example, incidents, trends, the maternity dashboard, staffing ratios, complaints and debriefs. Action plans had also been discussed in relation to serious incident reviews with target dates and progress reports.
- We saw information which demonstrated as part of the duty of candour 103 incidents had been reviewed during quarter three. The CGG also received information on serious incidents reviews, such as unplanned maternal admissions to ITU.
- The lead midwife for patient safety informed us that they selected the cases to be reviewed at the risk management meetings which took place every two weeks. These were multi-disciplinary meetings but were not attended by anyone directly involved in the incident. Feedback was said to be given to the member of staff and also to their midwife supervisor regarding overall view of practice.
- To ensure staff learned from incidents, a newsletter was circulated by email to each member of staff, copies of which we saw during the inspection.

Leadership of service

- Without fail all midwifery staff we spoke with conveyed positive feedback about the leadership at departmental level, visibility and accessibility of the lead matron, as well as them having a 'hands' on approach. Midwives also felt that both the Chief Executive Officer (CEO) and Director of Nursing (DON -occasionally referred to as Chief Nurse) were visible and communicated regularly. The CEO was said to hold workshops which anyone could and did go to. A consultant told us there was "very good midwifery management" and some younger midwives "would be successful matrons of the future".
- Trainee doctors told us about their experiences of leadership. One said the hospital was "very teaching and training orientated, and they felt "super, well supported." They said consultants were "always around" and there was "no bullying or undermining."
- Frimley Park Hospital NHS Foundation Trust board of directors won the award for Board/Governing Body of the Year at the National NHS Leadership Recognition Awards 2014, held February 2014, which offers a developmental prize of coaching and mentoring opportunities through the NHS Leadership Academy's expert faculty and the chance to share their work wider within the health service.

Culture within the service

- A junior doctor who spoke with us explained how they had been recommended to work at the hospital. They reported midwives and doctors as working well together and "being very happy to be working in the unit." A consultant with several years' experience of working at the hospital commented on the efficient "can do" culture and of "very good working relationships between doctors and midwives." The culture was said to go back a long time and everyone feels, "valued, lucky to work with patients who are pleasant" and "the culture comes from the top, the CEO knows everyone's name (consultant staff) and sorts things out."
- Another trainee doctor explained the positive way in which the multi-disciplinary team worked and said the "ethos is different from other places", the aim being to "emphasis normality for as long as possible".
- Midwifery staff, including student midwives who spoke with us also provided very positive comments on the culture within the hospital and department. This included positive aspects of the relationship with colleagues, friendliness and support of staff. The

longevity of staff and low turnover was said to be indicative of a positive working environment, good working relationships and of becoming a "Frimley person."

Public and staff engagement

- The maternity leadership team have involved women and their families in their development of services through the Maternity Services user Group and 'Maternity Voices'. This involves members of the team going out to the children's centres on a rotational basis to capture the views of women whilst their service and strategy was developed. Examples included the improvement of birthing environments; the renovation of delivery suite and the new MLU, where women and their families' views were taken into account.
- The trust holds a number of public constituency meetings to discuss plans on all aspects of their development of services to ensure the public are informed of developments.
- Members of the public including those who had used the service of the maternity department were encouraged to provide feedback on their experiences through the completion of commentary cards. There were arrangements in place to raise a complaint and have this investigated and responded to, with guidance displayed in all areas.
- Domestic and volunteer staff told us how they felt "part of the team." The domestic staff member explained how they could access the open forum held on a Wednesday, should they wish to discuss anything.
- We saw that staff briefing by the CEO were held at regular intervals and the date and time of these was advertised in advance by way of encouragement. Staff advised us that the CEO was visible and approachable.

Innovation, improvement and sustainability

- The programme of environmental improvements taking place were designed around enhancing the experience of women using the maternity services as well as being able to respond to the increasing demands of the local and more wider community.
- The maternity service had fairly recently set up a 'Facebook' page, which was being used to collect feedback and general commentary from people who had used --- service. An example of how information had been used to improve the experience of people using the service was the purchase of reclining chairs for partners to use whilst on the antenatal ward.
- A project team had recently undertaken work around collecting feedback on partner satisfaction during lower segment caesarean section (LSCS). Presentation of the outcome from this was made in May 2014. We saw that areas of good practice had been identified, such as scores of 98%-100% related to confidence in the anaesthetist and obstetrician, and having the opportunity to ask questions. In addition we saw that where improvements could be made, these were identified. The main point being that 44% of respondents did not know there was information on the website to help preparing for a caesarean section. We found from information provided to us that a pathway for fast tracking the discharge of women who had undergone caesarean section was in development. Another example of improvements related to the development of an information book about the caesarean section pathway. This was in written and pictorial form and was available in the antenatal clinics.

Services for children and young people

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

Information about the service

The children and young people's service at Frimley Park Hospital is provided on the Neonatal Intensive and Special Care Unit (NNU), the paediatric ward (F1), paediatric assessment unit (PAU) and the teenage unit (also located on F1).

Ward F1 has a total of 30 beds, of which 5 are dedicated to the care of young people (teenagers), a 4 trolley paediatric assessment unit, 4 level 1 high dependency beds, 5 medical beds/cots, 5 surgical beds/cots, 5 single and 1 double side rooms. There were 3,246 emergency admissions, 992 planned admissions and 3,149 ward attenders between April 2013 and March 2014.

The NNU has been assessed as a Level 2 neonatal unit by the local neonatal network meaning they can accept neonates from 27 weeks plus 6 days gestation or for babies born at a weight of at least 800 grams. There are 2 intensive care cot spaces, 6 high dependency and 8 special care cots. The unit received 553 admissions between April 2013 and March 2014 which equates to 10.4% of all births at the hospital for that same time period.

We visited all of the areas where children and young people were cared for including inpatient areas, theatres and the recovery department. We talked to 6 parents and their children, 21 members of staff, including nurses, student nurses, matrons, play specialists, doctors, consultants and support staff. We observed care and treatment being provided.

Summary of findings

Overall we rated paediatric services as good. We found children's services to be generally safe. However, we had concerns about nursing staffing levels and skill mix. For example, it had been identified as part of the annual clinical governance review that during periods of limited staffing, there had been an increase in medication incidents.

There were procedures in place to manage the deteriorating patient although the trust had identified that additional work was required to ensure that staff had the necessary skills to both identify and manage the deteriorating child.

Children's services followed national evidence-based care and treatment and carried out local audit activity to ensure compliance.

Children and those close to them, such as their parents or carers, were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. Leadership within the service was strong with a mostly cohesive culture. There was evidence of public and staff engagement as well as innovation within the service.

Services for children and young people followed the trust's incident reporting system and demonstrated that learning from incidents that took place there. Perinatal and clinical governance meetings were held and staff were able to demonstrate that learning from this meeting was taking place.

Services for children and young people

The children and young people's service was provided in a clean environment. Emergency equipment was checked in line with trust policy and was readily accessible and available.

Are services for children and young people safe?

Requires improvement

We found children's services to be generally safe; however, we had concerns about nursing staffing levels and skill mix. For example, it had been identified as part of the annual clinical governance review that during periods of limited staffing, there had been an increase in medication incidents.

The reporting of incidents was satisfactory and the feedback following the investigation of the incidents had improved. The wards and units we visited were clean and staff followed the trust's infection prevention and control policy. The equipment and environment was satisfactory in all areas and had been regularly checked and maintained.

Records were comprehensive and person-centred. People had risk assessments appropriate to their presenting condition. Procedures were in place to safeguard children and consent was obtained before any medical or nursing interventions.

There were procedures in place to manage the deteriorating patient although the trust had identified that additional work was required to ensure that staff had the necessary skills to both identify and manage the deteriorating child.

Staff were aware of their role in the event of a major incident.

Incidents

- The children and young peoples' service reported 4 serious incidents requiring investigation (SI) to the Strategic Executive Information System (STEIS) between April 2013 and March 2014. 3 incidents were attributed to the NNU and 1 occurred on the paediatric ward (F1). Each of the 4 incidents was investigated and there was evidence of learning as a result of the incidents. Two staff that we spoke with in the NNU and three staff from the paediatric ward able to describe the incidents that had occurred during 2012/2013; they were further able to describe the actions taken by the department to help to mitigate the risk of such incidents occurring again in the future.

- All incidents were reported through a centralised system called Datix. Senior nurses and consultants reviewed the incidents reported and analysed the data to identify any trends. Learning from incidents was disseminated to the staff team. Information was disseminated in a range of ways with examples including the "Neonatal News Letter", the use of information boards within staff rest areas and unit meetings.
- Table 4 demonstrates that the number of incidents reported annually has remained stable when compared with the activity of the department. Staff spoke positively about the culture of incident reporting within the department with staff telling us that they would receive feedback from incidents they had reported.

Number of incidents reported vs total number of patient contacts for ward F1

- Year 2011/2012: Patient Contacts (inclusive of F1 & Ward Attenders) = 6,620, Number of Incidents Reported = 117, Patient Contact/Incident Ratio = 1.76%
- Year 2012/2013: Patient Contacts (inclusive of F1 & Ward Attenders) = 7,778, Number of Incidents Reported = 140, Patient Contact/Incident Ratio = 1.79%
- Year 2013/2014: Patient Contacts (inclusive of F1 & Ward Attenders) = 7,390, Number of Incidents Reported = 128, Patient Contact/Incident Ratio = 1.73%

- The main trend originating from the incidents reported between April 2013 and April 2014 were attributed to supply, storage, prescribing or administration of drugs. Of the 128 incidents reported, 46 incidents related to drugs.
- Table 5 shows that the number of drug administration errors was seen to be increasing on an annual basis. This trend had been identified as part of the clinical governance report for the directorate of child health, dated 13 May 2014. An in-depth analysis of this trend was undertaken and changes to practice were implemented including an increase in pharmacist support to the ward, as well as providing real-time drug preparation guidance to nursing staff.
- Additional contributory factors associated with the number of administration errors that occurred on F1 were attributed to poor staffing levels as a result of staff sickness and also the high acuity and dependency of patients; the senior nursing team reported that they were now taking part in the national development of a paediatric acuity and dependency tool, which once completed, would allow the department to more accurately plan staffing on F1 so that the unit could meet the needs of all children and young people.

Year-on-year analysis of incidents relating to drug errors:

- Drug Errors by Sub Category; Administration: 2011/2012 = 9, 2012/2013 = 23, 2013/2014 = 26
- Drug Errors by Sub Category; Drug not available: 2011/2012 = 0, 2012/2013 = 2, 2013/2014 = 1
- Drug Errors by Sub Category; Dispensing: 2011/2012 = 1, 2012/2013 = 1, 2013/2014 = 4
- Drug Errors by Sub Category; Labelling: 2011/2012 = 4, 2012/2013 = 4, 2013/2014 = 4
- Drug Errors by Sub Category; Prescription: 2011/2012 = 33, 2012/2013 = 11, 2013/2014 = 8
- Drug Errors by Sub Category; Storage: 2011/2012 = 4, 2012/2013 = 5, 2013/2014 = 3
- Drug Errors by Sub Category; Discharge medication: 2011/2012 = 2, 2012/2013 = 4, 2013/2014 = 0
- Drug Errors by Sub Category; **Totals:** 2011/2012 = 53, 2012/2013 = 50, 2013/2014 = 46

- The NNU team regularly attended the Perinatal Mortality and Morbidity meeting at which the results of SI's were seen to be discussed and actions logged to help improve future care.
- Whilst the department did not hold regular paediatric morbidity and mortality meetings (due to the low frequency with which significant incidents involving the care and treatment of children in the department occurred), there was evidence that the department carried out mortality reviews as part of the departmental audit meeting. All mortality and morbidity reviews are fed into the trust-wide Mortality and Morbidity forum to allow for further scrutiny and increased governance of departmental performance.

Cleanliness, infection control and hygiene

- The department had a range of equipment, which was seen to be clean and well-maintained. Labels were in use to indicate when items of equipment had been cleaned.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.

- On F1 and NNU, there was a nominated link nurse for infection control who was actively engaged in the "Winning Ways – Working together to reduce Healthcare Associated Infection for England" initiative from the Chief Medical Officers office.
- Audit date from the "Winning Ways" audit for May 2014 identified that 92% of cot mattresses used on F1 were "Intact" and that the inside of all mattresses were free of staining.
- 100% of cot mattresses were reported as being in tact as of 13 June 2014.
- We observed staff appropriately decontaminate patient's skin, in line with the trust policy, prior to the insertion of venous and/or arterial catheters. "Data from the Winning Ways" audit demonstrated that in June 2014, 100% of staff whose aseptic non-touch technique was randomly assessed by an infection control link nurse was consistent with local policies and approved techniques.
- Staff washed their hands between each patient and we noted good usage of the hand sanitising gel.
- An infection control ward check carried out by hospital staff on 5 August 2014 reported that NNU and F1 were compliant in each of the 9 areas that were inspected.
- There was a programme for the deep-cleaning of clinical areas on a regular basis. F1 was reported as last undergoing a deep clean on 8 April 2014 and NNU on 19 June 2014.
- 73% of staff reported in the 2013 NHS staff survey that hand washing materials were always available. This compared with a national average of 56% (the trust performed better than the national average).
- As of 7 August 2014 there have been no reported cases of MRSA or Clostridium difficile for 2,773 and 2,257 days respectively.
- The NNU had a policy and process for the screening of MRSA on all patients admitted to the unit. On February 2014, the department reported 79% compliance with ensuring all patients were screened on admission. This had improved to 96% compliance in July 2014. The unit attained 100% compliance with the res-screening of all patients who had been on the NNU for more than 1 week in both the February and July audit.
- The children's ward had a process of isolating patients who presented with symptoms consistent with child-hood infections including chicken pox and measles of for those children suffering from diarrhoea and/or vomiting. Furthermore, on our first day of inspection we observed an area of good practice whereby a neutropenic patient was provided with protected time to use the play room without other children being presented, thereby reducing the risk to the child.
- As a Paediatric Oncology Shared Care Unit (POSCU) the department had access to, and routinely used shared care pathways for the management and care of central venous catheters including Hickman lines and portacaths. Winning Ways audit data for May 2014 demonstrated that the department was 100% compliant with those pathways.
- On 16 June 2014, representative from the Trust infection prevention and control team carried out an unannounced review of all patients with vascular devices in place on the NNU. 3 patients were identified as having vascular devices; the NNU achieved 100% compliance in the 6 areas that were reviewed including the on-going observation of vascular devices for signs of phlebitis as an example.

Environment and equipment

- The NNU was relocated from its existing location to a newly designed unit in December 2013. The neonatal high dependency and intensive care unit consisted of 6 cots; each bed space was configured to a similar format which enabled staff to navigate around each cot space with ease. Cot spaces were uncluttered and clean.
- Additional advancements include a designated expressing room which was furnished to meet the needs of new mothers. A multi-use side room had also been incorporated into the new NNU allowing staff to isolate patients who may have presented with contagious infections or where in the rare cases when treatment was to be withdrawn, families could spend time with their baby in a private area away from the main intensive care or special care unit.
- The NNU purchased a new internal transport incubator to assist in the transfer of neonates around the hospital; historically, new born babies were transferred by way of open resuscitaire units which offered little in the way of privacy and was not fully equipped with advanced life support equipment such as a ventilator, which is now no longer the case.
- Frimley Park Hospital attained stage 3 accreditation with the UNICEF UK Baby Friendly Initiative in 2013. The SCBU was "Particularly commended for the steps taken to ensure that parents have access to their babies at all

times during doctors' rounds. In order to ensure confidentiality parents who are with their babies during rounds, use (or are provided with) earphones so they can listen to music/radio preventing them overhearing confidential conversations. This practice has resulted in increased parent satisfaction and staff in the unit appreciated the positive impact this has on the parent/baby relationship".

- F1 had three non-clinical areas which were age specific; there was an under 5 play area, an over 5 play area and an adolescent area equipped with a kitchen area. Each area was equipped with age specific toys and electronic equipment such as games consoles. Each area was found to be clean and bright.
- Feedback from the patient experience survey highlighted that parents felt that the F1 environment offered them enough privacy to talk to staff and for examinations 100% of the time.
- There was a dedicated counselling room in the NNU to allow for sensitive conversations between staff and families to be held in private.
- There was sufficient equipment for resuscitating patients, and staff had been trained how to use it. Staff said they carried out equipment checks daily, and we saw this happening in practice.
- A range of "Point of Care" diagnostic devices were readily available within the paediatric assessment unit to allow staff to carry out tests during the initial stages of assessment and to help plan appropriate care and treatment.
- Staff working in the children's outpatient told us that they had identified that each of the consulting rooms were not attached to any form of alarm system and that the current doors did not allow for staff to view into rooms to ensure that staff were safe. Staff reported that due to the nature of some of the work their carried out such as genetic testing, there had been occasions when parents had become upset or agitated and staff had become concerned with their personal safety. We were told that actions in were place to address this and that door viewing panels had been ordered to help mitigate the risk to staff.
- Within the recovery unit we saw there was a designated area for children. Suitable age appropriate equipment was available in this area.

Medicines

- There were processes in place for ensuring medications were kept securely. Medication fridges were found to be locked when we randomly checked them. Fridge temperatures were routinely being recorded to ensure that medicines were stored as per the manufactures recommendations.
- Staff in the children's outpatient department were conversant with the importance of maintain the vaccine cold chain so as to ensure the efficacy of vaccinations.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs.
- We looked at five medical administration records on F1 (3 records) and the NNU (2 records) and noted that they were accurate, with no gaps. Patients' allergies had been recorded as appropriate. This was further supported by the F1 record keeping audit (May 2014) which reported that 100% of patients known to have a hypersensitivity or allergy had this recorded on their medication administration record. Weights were recorded to ensure that prescribed medicines were weight-specific in their dosage.
- The department was supported by a clinical pharmacist who carried out reviews of medication administration charts on a regular basis. An audit carried out in June 2014 demonstrated that 100% of patients on the NNU and F1 who had been prescribed antibiotics had been appropriate and that the NNU had attained 100% compliance with the antibiotic care bundle. F1 was noted to be 82% compliant with the antibiotic care bundle although this was an improvement on the previous audit dated March 2014 when compliance was reported as 68%.
- The children and young peoples' service was represented at the Trust Medication Safety Committee which met monthly. This ensured that any changes to medication practices, including medication related alerts from external agencies such as the National Patient Safety Agency could be disseminated to staff in the service.

Records

- We reviewed preoperative checklists for children who had gone to theatre. We noted that these were completed following the trust's policy for preoperative management.

- We reviewed three patients' care plans on the medical ward and two on the NNU. We noted that they were comprehensive and person-centred. Relevant risk assessments had been completed and there were daily evaluation records of whether people's health and emotional needs had been met.
- There was appropriate use of different pathways and protocols for medical and surgical conditions in the areas we visited. We noted that these had been comprehensively completed.
- During our inspection, we noted that records were kept securely and were accessible to healthcare staff, as appropriate.
- The directorate had implemented an electronic database, "Childex", which enabled staff to record and track medically expected patients.
- A record keeping audit of clinical notes was carried out on F1 in May 2014. 20 sets of notes were reviewed to determine whether they met the trusts requirements. 15 out of a possible 37 criteria were considered to fall below the trusts compliance threshold of 75%. An action plan had been devised to address the areas of non-compliance and a re-audit was scheduled to take place in February 2015.

Consent

- Staff obtained consent from patients appropriately and correctly. The staff we spoke with explained how consent was sought. This involved both the child and the person with parental responsibility.
- We noted that verbal and/or written consent was obtained on the medical and surgical wards, with signatures that stated it had been received.
- One of the parents we spoke with told us that the staff had fully explained the proposed procedure and possible complications before they gave consent.

Safeguarding

- There were appropriate processes for safeguarding patients against abuse. The department also had a multi-disciplinary Safeguarding Children Group, which met twice weekly to discuss recent safeguarding referral forms and ensure that any necessary action was taken. This had increased from a weekly meeting due to the increase in safeguard referrals being made with 211 safeguarding children referrals made in May 2014 and 401 referrals reported in total for quarter 1 of 2014 (April-June 2014) .
- The Directorate of Child Health Clinical Governance report dated 13 May 2014 identified that there had been an increase in the number of safeguard referrals being made within the service. A request for additional support was submitted and the lead safeguard nurse has reported that the trust have responded by providing an additional 15 hours of midwife support as of September 2014 and an additional 15 hours of nurse support from October 2014 to help manage the case load.
- There were also systems in place for referring children and adolescents to the local Child and Adolescent Mental Health Service (CAMHS).
- Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.
- A policy relating to Safeguarding Children was readily available and accessible and had been reviewed in June 2014.
- With the exception of one nurse, all nurses working within the CYP service had completed child protection training to level 3.
- The hospital had a Consultant lead, named nurse and named executive safeguarding children.
- The areas within children's services were supported by a safeguarding nurse who we saw visit each clinical area on a daily basis.
- Junior doctors received training in safeguarding vulnerable children as part of their initial induction to the department.

Mandatory training

- Compliance with mandatory training was seen to be good in NNU however the data provided for staff working on F1 revealed the compliance with mandatory was not as good.
- 97% of NNU staff had completed their mandatory training, with 100% of staff having completed information governance, equality and diversity training. 88% of NNU staff had completed training in basic life support.
- There was some disparity between the data provided to us by the trust. We received training information data from two sources: the paediatric dashboard and a print out of the electronic training database for F1. The paediatric dashboard reported that 100% of staff had attended paediatric life support training whilst we

calculated that only 42% of staff from F1 had completed their mandatory training in patient safety and had attended a paediatric life support course in the preceding twelve months.
- 31% of staff from F1 had completed their training in fire safety awareness training.

Assessing and responding to patient risk

- The children's wards and the high dependency unit used the Paediatric Early Warning Score (PEWS). This helped to determine if there was deterioration in a patient's condition. There were clear instructions for escalation printed on the reverse of the observation charts.
- Following a recent SI on F1 when the condition of a child deteriorated, it was recognised by the division that staff required additional training in the use of PEWS. In addition the department have recognised the importance of providing supplementary training to staff in the early recognition of the deteriorating sick child. A revised PEWS training e-learning module was in the process of being developed at the time of inspection.
- The charts that we reviewed showed that observations had been undertaken within the appropriate time frames, with clear documentation of the patients' PEWS score.

Nursing staffing

- NNU nurse staffing ratios were assessed by the use of the British Association of Perinatal Medicine (BAPM) acuity tool. Any staffing shortfalls were backfilled by the unit's own staff, therefore removing the requirement to utilise agency staff.
- The NNU employed one advanced nurse practitioner who was supervised by the matron and a named consultant. Three band 6 nurses had undertaken additional post-graduate training and had been assessed as competent to carry out new-born and infant physical examinations in line with the requirements of Public Health England and NICE Quality Standard 37: Postnatal Care Pathway and quality statement 7: Infant Health – physical examination.
- Both the NNU and F1 reported no vacancies within the nursing establishment at the time of inspection.
- The number of nurses qualified in the speciality of neonatal medicine was 63% of the total NNU workforce versus a national benchmark of 70%. 3 further nurses were in the process of undertaking post-graduate training in neonatal intensive care (raising the number of specialist nurses to 75%).
- The lead matron for NNU reported that whilst the department had expanded the number of HDU cots by 3, there was currently no additional demand for those cots, and as such, had not actively increased the nursing workforce; this remained under review by the matron who reported that they would increase the workforce as demand increased in the unit.
- We spoke with staff on F1, who expressed concerns about the staffing levels. One member of staff described the ward as "Nearly running on empty". Although no formal acuity tool was being used, staff on F1 had engaged in a national audit programme, coordinated from University College of London Hospital (UCLH) in developing a tool specific to the needs of children and young people. This audit programme was in the process of being reviewed by UCLH and had not been adopted formally by the ward.
- Three parents that we spoke with during the inspection reported that they considered there to be sufficient numbers of nursing staff; they had not experienced delays in their children receiving nursing care and staff were reported to have answered the call bells promptly.
- The department had submitted a business case to increase the daily nursing establishment in order that they could meet the recommendations of the Royal College of Nursing guidance titled "Defining staffing levels for children and young people's services" (2013).
- Staff further reported that as of September 2014, the ward would be required to provide 2 nurses each week day to care for children admitted directly to the day surgery unit. These posts had not been budgeted for, and so formed part of the business case dated 7 July 2014.
- Ward F1 had a four bedded High Dependency Unit, which, according to the trusts self-assessment against the Paediatric Intensive Care Society (PICS) Standards, was listed as a level 1 high dependency unit. PICS standards require a nurse to child ratio of 0.5:1 when the child is categorised as requiring level 1 high dependency care in an open bay (or 1:1 if a high dependency, level 1 child is nursed in a cubicle). The department considered that they were non-compliant with this PICS standard. The business case submitted to the executive team requested that the "absolute minimum" establishment

for HDU should be 1 nurse, 24 hours per day which meant that the departmental minimum establishment would still not be sufficient to meet the PICS staffing requirements.
- The self-assessment form, and data provided by the trust reported that only 2 nurses from F1 had undertaken post-graduate education in the management of the high dependency child therefore listing the unit as only "Partially compliant" for this PICS outcome.
- We noted a level of disparity between the nursing hierarchies within children's outpatients when compared to adult outpatients. Children's outpatients employed a range of care assistants, band 5 nurses and a band 7 unit sister/charge nurse. There were no band 6 posts within the establishment as compared to adult out-patients. Staff reported that they felt as though they were not in a position to develop band 6 managerial experience if they remained in children's outpatients.

Medical staffing

- Consultant paediatricians were present on the NNU and F1 from 08:30 until 21:00 during the week. At weekends, consultant cover was provided from 08:30 until a full ward round of ward F1 and NNU had been carried out.
- Outside of these hours, a consultant was available on an on-call basis and was available for telephone support 24 hours per day.
- A separate full attending consultant system was in place during the week to ensure that the NNU and F1 were supported by separate consultants.
- The department operated separate middle grade doctor cover for NNU and F1.
- There were medical handovers at 08:30 for both NNU and F1. We observed the 08:30 handover and saw evidence of good multidisciplinary working. The handover was consultant-led and structured. An additional two consultant supervised departmental handovers took place during the week and once daily at weekends.
- The departmental clinical governance report dated May 2014 made reference to the ongoing issues regarding the national shortage of middle grade doctors. Junior doctors told us that there were occasional vacancies on the Specialist Registrar rota which was consistent with what we were told by the clinical director for the service.
- During May, June and July 2014, the NNU reported having a dedicated middle grade doctor 100% of the time and in April 2014, it was reported that a middle grade was available 98% of the time.
- During the inspection, we noted that there had been an increased presence of specialist registrar doctors as we were inspecting during the rotation of foundation year doctors; this was considered as a positive way of managing the risks associated with the rotation.

Major incident awareness and training

- The trust had a major incident plan which was available on the intranet. Senior nursing staff were aware of the plan and were able to explain their roles and responsibilities as part of a major incident. Senior nurses were able to direct us to the major incident action cards which were located on the ward.

Are services for children and young people effective?

Good

With regard to effectiveness we found that overall, the service provided to children and young people was good.

We found that staff were competent and had received specialist training although there is a requirement for the department to review how it records training data to ensure records are accurate. The nursing staff also told us they could access clinical supervision and support when they required it.

We found that care and treatment was evidenced based and followed accepted standards and professional guidance. However, an audit of the limitation of treatment agreement policy had found that staff did not always follow the policy although there was an ongoing action plan in place.

We found there were systems in place that ensured patients had adequate pain relief at the right time. There were also no concerns identified with the provision of nutrition and hydration for patients.

Evidence-based care and treatment

- The children's services used the NICE, Royal College of Paediatrics and Child Health (RCPCH) guidelines to define the treatment they provided.

- There were pathways and protocols of management and care for various medical and surgical conditions. We saw documented evidence that these were used, and updated appropriately, if there were any changes in the national guidelines.
- We saw evidence that where exceptions to national practice were warranted, there was a decision and audit trail in place. For example, NICE clinical guideline 151: Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients recommends that patients are treated with beta lactam monotherapy antibiotics only and that the inclusion of an aminoglycoside should not be offered. The department continued to offer dual therapy treatment because this was indicated due a high occurrence of resistance to the recommended beta lactam antibiotic within the south east of England.
- NNU were seen to utilise and reported that they were compliant with the use of NICE Clinical Guideline 149: Antibiotics for early-onset neonatal infection: Antibiotics for the prevention and treatment of early-onset neonatal infection.

Pain relief

- There was a process in place for ensuring that neonates received oral sucrose as a means of reducing their pain response during procedures such as heel prick blood screening and lumbar punctures.
- We saw that the NNU utilised kangaroo care as a means of helping to stabilise neonates.
- Children admitted to the ward underwent age appropriate pain assessments. A review of five care records demonstrated that staff were routinely assessing children's pain levels.
- The department had access to a policy titled "Guideline for the management of acute pain in paediatric inpatients (from age 1 year upwards). The policy was evidence based and provided staff with guidance on managing varying levels of pain.
- There were numerous distraction therapies and techniques throughout the children's services to help reduce the patients' pain and distract them from painful procedures. Play specialists and play assistants were available to assist the medical and nursing teams, as required.
- Children admitted to the unit as part of the POSCU scheme were provided with information produced from a third party specialist service (The Royal Marsden NHS Foundation Trust) advising children and young people of the various analgesics available to them during their chemotherapy and/or radiotherapy treatments.

Nutrition and hydration

- We noted that drinks, snacks and an appropriate choice of food was available for children and young people. Multiple faith foods were available on request, and special reference was made to the availability of Nepalese food due to the high Nepalese population in the area.
- Breastfeeding mothers were provided with free meals whilst their child or new-born were inpatients in hospital.
- Food for children was delivered to the ward from a "Thomas the tank engine" serving unit.
- NNU and the maternity unit have attained stage 3 of the UNICEF Baby Friendly initiative which indicates that mothers have reported receiving information and support regarding breast feeding.
- Although the NNU did not operate a donor milk service, there were arrangements in place to source specialist donor milk form neighbouring level 3 neonatal intensive care units on an as required basis.
- Between April and July 2014 100% of babies born at less than 29 weeks gestation, and weighing less than 1000grams received parental nutrition once admitted to the NNU.
- In January and February 2014, the NNU attained their target of ensuring that at least 62% of babies born at less than 33 weeks gestation were receiving at least some breast milk. This target was not attained in June and July when the compliance rates were recorded as 50.0% and 57.1% respectively.
- Children and young people admitted to F1 underwent a nutritional screening assessment; dietetic referral pathways were available for any child or young person identified as being at risk of mal-nutrition, or for children who had specialist requirements such as high calorie meals as an example.

Patient outcomes

- There was no evidence of risk that the trust was an outlier regarding paediatric and congenital disorders and perinatal morbidity.

Services for children and young people

- Children's services submitted a range of data to national audit programmes. This included the National neonatal audit programme, Paediatric Asthma Audit, Childhood epilepsy and the National Paediatric Diabetes Audit.

National Neonatal Audit Programme Performance:

- Data from the 2011 National Neonatal Audit listed Frimley Park Hospital as a low outlier in that; there was not always a documented consultation with the parents/carers by a senior member of the neonatal team within 24 hours of admission. The trust responded to this outlier alert by providing the National Neonatal Audit Programme facilitators with an action plan to address the issue. During our inspection we saw evidence that parents/carers were routinely been counselled by the duty consultant in a timely manner, although it was too soon to determine whether the unit had made the necessary improvements when compared to national performance.
- 78% of eligible mothers were given antenatal steroids; that is mothers who were due to deliver their baby between 24+0 and 34+6 weeks gestation. The national standard is that 85% of mothers will receive any dose of antenatal steroid. The national performance for similar units i.e. special care units was 75%. The trust therefore performed better than other units in this standard.
- All babies born with a gestational age of less than 32+0 weeks or weighing less than 1501grams at birth should undergo timely Retinopathy of Prematurity (RoP) screening in accordance with national guidance. Data from the 2011/2012 national neonatal audit indicates that Frimley Park attained 6% compliance in this outcome. This compares with a national average of 44% for other special care units. This area of poor performance has since been addressed; the NNU dashboard indicated that between April and July 2014, 100% of eligible babies underwent timely RoP screening.

Paediatric Diabetes Unit Patient and Parent Reported Experience Measure Performance

- In response to the question about whether patients receive the necessary advice from the hospital 24 hours per day about their diabetes, the hospital performed worse than the national median with an overall satisfaction rate of 59.5% compared with a national percentage of 70.9%.
- In comparison, 92.9% of patients reported that they could access advice from a member of the diabetes team during normal working hours Monday to Friday, compared with a national percentage of 89.4%.
- 59.9% and 59.5% of patients reported receiving enough information to enable them to manage high and low blood glucose levels respectively. This is comparable with the national averages of 56.5% and 58.8% for high and low levels respectively.
- 50% of patients reported that they strongly agreed that they were given sufficient information to help them manage illness associated with diabetes. This again was marginally better than the national average of 47.2%.
- The paediatric diabetes unit scored considerably worse when patients were asked whether they strongly agreed that they received sufficient information about carbohydrate counting (14.3% vs 49.1% nationally) although it is important to note that 42.9% of patients said they agreed versus 36.3% nationally. Additionally, 16.7% of patients selected "Not applicable" to this question compared with 6.6% nationally.

National Paediatric Diabetes Audit

- 2011/2012 was the first year that the trust had provided data regarding hospital admission related data as part of this audit so it was not possible to compare the trusts performance on previous years. However, when compared nationally, the incidence rate of children admitted to hospital with hypoglycaemia was 9022.6 per 100,000 population. This was better when compared nationally whereby the incidence rate was reported as 12995.9 per 100,000.
- Quality Standard 6 of the National Institute for Health and Care Excellence Diabetes in Adults recommends that patients with diabetes agree to maintain a personalised HbA1c target of between 6.5% and 7.5% and receive an ongoing review of treatment to minimise hypoglycaemia. This guidance is also considered as part of the National Paediatric Diabetes Audit. During 2011/2012 20.7% of patients treated by the Frimley Park Hospital Paediatric Diabetic Unit were reported as achieving an Hba1c Target band of less than 7.5%: this was compared with a national average of 17.4%. 60.3% of patients maintained a Hba1c target band of between 7.5% and 9.5% which was better when compared nationally (57.5%). 19.0% of patients were maintaining a Hba1c target of greater than 9.5% which continued to still be better when compared nationally (25.0%).

Services for children and young people

RSV Prophylaxis Programme

- In 2010, the Department of Health issued new recommendations for the use of Palivizumab immunisation to protect infants at risk of serious respiratory syncytial virus (RSV) infection.
- During 2013/2014 13 babies were identified as meeting the strict qualifying criteria to receive RSV immunisation. The NNU carried out a qualitative study which identified that 10 of the 13 babies who received RSV prophylaxis because they had chronic lung disease and had been discharged home with supplementary oxygen were not admitted to the hospital with bronchiolitis despite being at high risk.

Royal College of Paediatrics and Child Health – Facing the Future Performance

- 75% of children were seen by a paediatrician on the middle grade of consultant rota within 4 hours of admission. This was marginally below the national average of 77%.
- 100% of children were seen by a consultant paediatrician within the first 24 hours.
- The trust had a system in place for ensuring that staff had access to a consultant paediatrician with level 3 safeguarding competencies 24 hours per day, 7 days per week.

Competent staff

- Junior medical staff reported good learning opportunities and reported feeling supported by the consultant team. The General Medical Council (GMC) National training survey (2013) reported that paediatrics performed below the expected range for clinical supervision and for gaining adequate experience. The clinical director made reference to the fact that the number of middle grade doctors completing the GMC survey for 2013 was extremely low which may have been a contributing factor to the worse than expected outcome for the two areas. However, it was noted that paediatrics performed better than expected for workload.
- The paediatric database reported that as of April 2014, 90% of nursing staff had undergone an appraisal. The staff that we spoke with told us that they considered the appraisal system to be beneficial to their personal and professional development.
- 3 consultants are accredited Advanced Paediatric Life Support Instructors.
- 2 consultants are accredited Neonatal Life Support Instructors
- 3 consultants and 1 nurse are trained in simulation scenario training
- All band 6 and band 7 NNU staff are trained in neonatal life support.

Facilities

- The NNU has been designed to meet the needs of the neonate and family in line with BLISS requirements. This includes two family rooms and reclining chairs for every cot side to promote kangaroo care. The NNU was awarded with a “Pledge of Improvement” by the national charity BLISS for “Working towards accreditation of high quality family centred-care”.
- The NNU is reported to be the first NNU within the Kent, Surrey and Sussex neonatal unit to have introduced mood lighting into the department which has been shown to enhance neurodevelopment of the neonate.
- The NNU has two electronic sound systems to monitor decibels; these were suitably placed and were to be effective in reducing sound pollution within the unit.

Multidisciplinary working

- Physiotherapists, speech and language therapists and dieticians visited the children’s wards and provided continued support to children and young people and were seen to be integrated into the wider paediatric team.
- We noted that young people up until the age of 18 were cared for within the service and saw evidence that their transition into adult services was managed effectively; this was especially noted for young people with diabetes.
- There were arrangements in place for the retrieval and transfer of critically ill children and babies to appropriate level 3 paediatric intensive care units or to tertiary neonatal intensive care units.
- Children and young people who were in need of mental health or psychological support had access to specialist input. However, staff reported that it was often difficult to refer children aged 16 – 18 years to the CAMHS service as they were considered to fall outside the age referral range. This was being monitored at a local level by the ward to determine the impact that this may have long-term for adolescents admitted to the teenage unit requiring mental health support.
- Minutes from the monthly perinatal meetings evidenced that there was good attendance from both the Obstetric

and Neonatal Teams. The meeting allowed for discussions to take place regarding any imminent high risk pregnancies which would potentially impact on both the neonatal and obstetric service.
- The paediatric service was recognised as a Paediatric Oncology Shared Care Unit, networking with tertiary cancer centres including the Royal Marsden NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust.
- Additionally, Frimley Park Hospital worked closely with other providers in the provision of regional cystic fibrosis services.

Seven-day services

- Patients had access to allied health care professionals such as physiotherapists outside of normal working hours including weekends. In addition, staff were able to access radiology services 24 hours per day with urgent electronic reporting available over night.

Are services for children and young people caring?

Outstanding ☆

We considered that the staff at Frimley Park Hospital provided care which was compassionate, empathetic, dignified and respectful. Overall, we judged that this domain was outstanding. Staff were committed to providing holistic, family-centred care to children and their families.

People spoke positively about the care they received; the department went above and beyond the call of duty to seek feedback from children, young people and their parents/carers by using a range of different, age appropriate approaches in order that the service could review its performance and to improve where necessary.

Compassionate care

- The NNU was participating in a one year Picker Institute parent experience survey; this survey had not been concluded at the time of the inspection although information on the survey was available to parents/carers.
- Senior nursing staff on NNU meet with each family prior to discharge so that they can capture real-time, face-to-face feedback on the service they have received.
- Ward F1 and children's outpatients sought feedback from patients in a range of ways, ranging from the use of token system which was used to be used by children to provide feedback on the care they had received. Children in the outpatients department were encouraged to complete "Experience balloons" which were then placed onto a public display board. Additional forms of feedback were captured by way of real-time electronic surveys however staff on F1 reported that the electronic devices did not always connect with the wireless system so patients were not always able to complete the form.
- Feedback from the 2014 Paediatric Oncology patient/user satisfaction survey reported that 90% of patients were satisfied with their medical care and 100% of patients reported being satisfied with their nursing care.
- The paediatric oncology service reported that there had been an overall improvement experienced by patients/users with regards to the communication between different health care professionals (43% in 2012 increasing to 89% in 2014).
- When compared nationally, the paediatric diabetes team performed better with regards to the question of "On a scale of 0 to 10, how likely is it that you would recommend this clinic (Paediatric diabetes clinic) to a friend or another family with a child who has diabetes". Frimley Park Paediatric Diabetes Unit scored a median score of 9.31 (indicating a high level of satisfaction). The national median score was 9.02.
- Throughout our inspection we observed children and their families being treated with compassion, dignity and respect.
- All of the parents and relatives that we spoke with were positive about the caring, friendly staff. They said the care their child and themselves received was kind, compassionate and supportive.
- We saw doctors and nursing staff introduce themselves to families and curtains were drawn to maintain patient dignity.

Patient understanding and involvement

- The NNU provided outreach nursing support to parents/carers whose baby was scheduled to be discharged home after having received treatment in the NNU.
- We observed consultant ward rounds taking place in the NNU. Parents were present for the handover; the consultant spent time speaking with the parents and provided many opportunities for them to ask questions

about the care and treatment plans for their babies. In addition, we noted that the consultant took the time to ask the mother of the baby about their own health and wellbeing.
- We visited the patient advocacy liaison service who reported a very low number of complaints reported against the paediatric service. The PALS team had developed a "Mr Men" age appropriate poster which was placed throughout ward F1. The redesign of the PALS poster was instigated following feedback from young children.

Emotional support

- We saw children and families being reassured by the nursing staff and heard explanations of their care being given.
- There were a range of clinical nurse specialists employed to support children and their families. The parents that we spoke with were highly complementary of the nurse specialists.
- The NNU team provided an outreach service which included bereavement support to families.
- In addition to providing support to local service users, the NNU outreach service also visits tertiary intensive care services to meet with families whose baby is likely to be repatriated back to Frimley Park Hospital.
- As a result of feedback from a local epilepsy service survey, a clinical nurse specialist was appointed to support patients with long-term health needs associated with epilepsy and attention deficit and hyperactivity disorders.
- There were processes in place for supporting the parents/carers and siblings of children receiving palliative care.
- There were support mechanisms and care plans in place to meet the individual needs of children receiving oncology therapies such as chemotherapy and radiotherapy.
- Staff reported that they were actively encouraged by the management team to utilise the time garden for memorial services as well as incorporating the use of the time garden in the planning of end of life care.
- There were systems in place for bereaved families to meet with consultant paediatricians at a time and place that was suitable to the family in order that they could discuss the care and treatment their child received.
- The NNU facilitated regular parent support groups.

Are services for children and young people responsive?

Good

The service was found to be responsive to the needs of the local community. Despite an increase in the number of patient contacts reported across the directorate, appropriate planning, service delivery and unit design had enabled the department to absorb the increase with a degree of flexibility to accept additional cases in the future.

There were many positive examples of how, as an integrated service, children's services were able to meet the ever increasing and more complex needs of children in the local community. Such services were seen to have a positive impact on the local population, with reductions in the number of children with co-morbidities and complex needs being admitted into the hospital.

Service planning and delivery to meet the needs of local people

- The neonatal unit received 553 admissions between April 2013 and March 2014 which equates to 10.4% of all births at the hospital for that same time period. This was comparable with admissions to the unit during 2012/2013 when the NNU admitted 577 babies which equated to 10.4% of all births at the hospital for that same time period.
- The NNU moved from its existing location to a newly refurbished department in December 2013; the design took into consideration the future needs of the local population by increasing the number of high dependency cots from 3 to 6.
- Ward F1 received 3,246 emergency admissions, 992 planned admissions and 3,149 ward attenders between April 2013 and March 2014. This was an increase of 767 patient contacts when compared to 2011/2012.
- In order to manage the increasing demand on the service, additional initiatives have been instigated by the department including the move of day case surgery from ward F1 to the main day surgery unit; this was scheduled to take place in September 2014 and was in response to the local demand for additional paediatric surgical provision to take place at Frimley Park Hospital instead of referring patients to Southampton for treatment as is currently the case.

- In addition, patients referred to the hospital by primary care services that required a review from a middle grade paediatrician are referred to be seen in the Paediatric Assessment Unit instead of being referred to the ED or admitted to the ward. The PAU policy states that patients must be seen within an hour of arrival by a middle grade doctor; an audit demonstrated that this occurred in 90% of cases. 95% of patients remained in the PAU for less than four hours before a decision was taken to admit, transfer or discharge the child.
- The department had developed an ambulatory care model, which in 2013/2014, treated 1,400 patients. This has included the administration of intravenous antibiotics to children and young people who would have otherwise been admitted to the ward until their antibiotic therapy had been completed.

Access and flow

- Between April and July 2014, the number of special care cot days (bed occupancy) exceeded the trusts target range of having less than 80% occupancy (April: 127%, May: 128%, June: 99%, July: 158%).
- Neonatal high dependency cot days were reported as April: 30%, May: 19%, June: 15% and July: 17%.
- Neonatal intensive care cot days were reported as April: 47%, May: 40%, June: 17% and July: 26%.
- Despite the high occupancy of special care cots', there were no reported incidents between April and July, whereby the unit was required to close because of insufficient capacity. The NNU reported 5 unit closures during 2012/2013 as a result of being full to capacity. Staff reported that the additional 3 cots within the HDU provided them with a degree of flexibility to accept more babies during peak times without the need to close the unit or to transfer babies to another neonatal unit.
- The department provided a rapid access clinic which allowed for up to 16 children to be assessed by a senior clinician each week instead of being referred to be seen in a paediatric outpatient clinic. This ensured acutely unwell children were seen by an appropriately qualified clinician in a timely fashion.

Meeting people's individual needs

- Translation services were available for patients and families for who English may not have been their first language.
- The service operated an "Open Access" policy for specific patient groups. This offered parents/carers the reassurance that should the condition of their child deteriorate at any time, they could report directly back to the ward without the need to go via the emergency department.
- Nursing staff in the paediatric outpatient department operated a range of nurse led clinics including a BCG vaccination clinic for high-risk babies. Staff had increased the number of clinics provided because it was reported that the waiting list had previously increased to six months. At the time of the inspection, the lead nurse responsible for the clinic reported that the waiting time had been reduced to 7 weeks. Proposals had been developed for staff to consider the administration of the BCG vaccine to high risk babies following their birth as a means of managing the waiting list in the future.
- There was evidence that the department had engaged with local clinical commissioning groups to secure funding in order to be able to offer education sessions and advice to general practitioners, schools and to parents. This has included education packages being devised by the diabetes nurse specialist team to help support schools to manage children with type 1 diabetes.
- There were systems in place for providing children who had been in hospital for 10 days or more with education other than at school, a Department of Education initiative to ensure that children continue to receive education whilst they are outside of the formal school environment.
- Outpatient clinics were facilitated in a range of satellite locations spanning across Surrey, Hampshire, and Berkshire.
- Food tokens were available to parents to enable them to purchase hot food and drink from the hospital at a discounted rate.
- Prior to discharge, parents/carers of babies who had received treatment on the NNU were invited to attend neonatal resuscitation classes as well as being provided with a DVD explaining neonatal life support.
- There were adequate facilities for breastfeeding mothers, throughout the children's services.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child's bed. There was limited parental accommodation for parents whose children had to stay in hospital for a long period of time.

Services for children and young people

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). A dedicated member of staff within the paediatric and NNU team reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging. Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.
- Information was readily available for patients who wished to make a complaint, but who may have required support in doing so.
- Overall, the ratio of complaints lodged against the department, versus the number of admissions and attendances was low (0.04%). There was evidence that complaints were shared with members of the team in order that lessons could be learnt. Trends arising from complaints were discussed as part of the clinical governance system within the department.
- Where the trust had been requested to respond to Regulation 28 orders, the trust has been seen to respond to such requests in a timely fashion. We found that they had provided the necessary information to demonstrate that actions had been implemented to address any concerns as a result of the Regulation 28 order.

Are services for children and young people well-led?

Good

There was a strong clinical and nursing leadership structure within the directorate. Staff spoke positively about working at Frimley Park Hospital. Improved recruitment within the NNU and Children's ward had a positive impact on the working conditions of staff within the unit.

Senior staff who were allocated lead roles spoke passionately about the importance of such roles, and it was apparent that the staff were committed to improving the level of care they provided to the local population.

Both the NNU and Children's services were seen to actively participate in national and local research in order that long-term standards of care for children could be improved.

Vision and strategy for this service

- The department had considered a range of developments to further enhance the provision of services for neonates, children and young people in the future.
- The neonatal team were keen to advance their clinical practice in order that they could contribute to the improved outcomes of babies born prematurely. This included the introduction of neonatal cooling and cerebral function monitoring to assist in the management of hypoxic ischaemic encephalopathy.
- The children's' service had considered the Royal College of Paediatric and Children Health "Facing the Future" with regards to improving the standard of care for children and young people; their vision was seen to be aligned to the national agenda.

Governance, risk management and quality measurement

- A robust clinical governance system was in place in the department. One consultant had been appointed as the governance lead, and regular reports were produced to demonstrate the effectiveness of the department.
- The report provided a balanced view of the department. The consultants and senior nursing staff that we spoke with were clear about the challenges the department faced. They were each committed to enhancing the patient journey and were actively involved in some form of developmental working group within the department.
- A departmental risk register was available and was under continual review to ensure that the content of the register was reflective of the real-time risks within the department.
- Bi-monthly clinical governance minutes took place which covered all clinical areas within the directorate and the neonatal unit. The clinical governance committee were seen to engage with relevant speciality areas including the resuscitation team, safeguarding representatives, pharmacy, occupational therapy and physiotherapy.
- There was a process in place for ensuring that where new guidance had been issued by external

organisations such as the National Institute for Health and Care Excellence, these were discussed at the governance meeting and actions recorded if amendments to policies were required.
- We saw that the Children's service responded effectively to serious incidents and learnt lessons from those events.

Leadership of service
- Each of the three internal divisions of children's services (NNU, General Paediatrics and children's outpatients) were well led. Staff had clearly defined roles and responsibilities which demonstrated good leadership across the division.
- The efforts of the NNU nursing leadership were identified as being of a particularly outstanding standard in light of the improvements that had been made to the service over the previous 3 years.

Culture within the service
- The service had an open and friendly approach with team working being reported as strong and effective.
- There was a drive and motivation amongst staff to enhance the standard of care that was provided across the directorate.

Public and staff engagement
- Patient feedback was widely displayed throughout the various departments.
- There was a range of systems in place to seek the engagement of members of the public.

Innovation, improvement and sustainability
- The concept of developmental care within NNU was seen as embedded practice.
- The NNU operated an outreach service. The purpose of this service was to enhance the discharge pathway for a range of neonates who were admitted to the NNU. We found that some neonates could be discharged earlier than anticipated because parents were supported by the outreach service.

End of life care

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

Information about the service

End of Life Care Services were provided across the hospital and were not seen as being the sole responsibility of the Specialist Palliative Care Team (SPCT). There were 1125 deaths at Frimley Park Hospital in 2013. With an increasing population of older patients with multiple co-morbidities and complex medical needs the challenge for staff to identify patients in the last days of life was growing and this was acknowledged by the trust with work being done to address this.

Within the hospital, the SPCT worked collaboratively with all clinical teams to support End of Life Care (EOLC). There were strong working relationships with the acute oncology service and tumour site specific clinical nurse specialists with palliative care representation at the lung cancer and cancer of unknown primary multidisciplinary team meetings. The liaison service supported all adult patients nearing the end of life and there were particularly good links with the respiratory, cardiology and stroke teams.

The number of patients referred to the SPCT had increased in recent years with 966 patients being referred in 2012-2013. Of these, 88.8% were over 65 years of age with 42.1% being over 84 years of age.

As part of this inspection we visited eight wards looking specifically at EOLC and reviewed the medical and nursing records of 26 patients. We observed care being delivered on the wards and spoke with 18 patients, most of who were identified as requiring EOLC. We also spoke more generally with other patients about the overall care provided on wards and the attitude of staff. We met and spoke with numerous ward staff including healthcare support workers, junior nurses, and ward managers. As they had only just started in their posts we only spoke briefly with two junior doctors. We met the chaplains and the mortuary manager and were shown the resources and facilities they had available to them. We also met with the equality and diversity lead for the Trust. A focus group of members of the SPCT allowed us to speak with them about the details of the service they provided.

End of life care

Summary of findings

Overall we rated end of life care as outstanding. We found that Frimley Park Hospital was providing an exemplary quality of care to people approaching the end of their life. The few areas where there was potential for improvement had been identified and we saw evidence that work was in progress to make the service even better.

The trust's End of Life Care (EOLC) Steering Group, which was responsible for the overall monitoring of the provision of EOLC, was established in 2008. It had developed policies and procedures to support end of life care and had a diverse multi-disciplinary membership from both the trust and local community. The EOLC Steering Group was chaired by the Clinical Director for Surgical Services, which meant that the trust strategy for end of life care was disseminated well across all services and we found that there was good 'buy in' to the end of life policies from staff working outside the SPCT.

The hospital's palliative care team saw approximately 1,028 patients in 2013/14. Of these, 51% were non-cancer patients, which showed a good balance between cancer and non-cancer patients being provided with the specialist services of the palliative care team. We were told that 45% of patients who died at the trust were referred to the specialist palliative care team, which compares well with the national average of fewer than 40%. Where people received specialist palliative care input, less than a quarter (23.9%) died in hospital compared to national data for all deaths that showed 51.5% of people died in hospital nationally. This means that the good access to the expertise of the SPCT, coupled with a robust discharge policy, allowed more people to die where they wanted and reduced both the length and frequency of admissions for end of life care.

The trust had implemented the AMBER care bundle system, which provided a systematic approach to manage the care of hospital patients who were facing an uncertain recovery and who are were at risk of dying in the next one to two months. The AMBER care bundle was developed at Guy's and St Thomas' NHS Foundation Trust. It was part of a programme funded by the Guy's and St Thomas' Charity to improve the quality of care of patients who are at risk of dying in the next one to two months but may still be receiving active treatment. It does not change a patient's treatment or care – it helps staff to realise when they should talk with the patients about what treatment and care they would prefer if they do not recover.

The trust's staff talked with enthusiasm about their proactive stance in getting people home to die if at all possible. This was supported by a strong rapid discharge policy that was sufficiently resourced to make it workable. The first national VOICES survey of the bereaved (2012) suggests that 71% of people wanted to die at home but that only 29% of people nationally who died in hospital felt they had sufficient choice about this. A strong culture of enabling rapid discharge supports people and their families in their desire to die in their home surrounded by the people they love and within a familiar environment that they retain more control over. We were told that the shortest recorded discharge was just 45 minutes but that this was not the norm; a one-day target for making the necessary arrangements for a safe discharge was more usual.

A review of the data showed that the trust had robust policies and monitoring systems in place to ensure that it delivered good end of life care. However, it was the direct observation and conversations with staff, relatives and patients that made us judge the care outstanding. Individual stories and observed interaction provided assurance that staff of all grades and disciplines were very committed to the proactive end of life care agenda set by the board. One healthcare support worker said, "Is it odd that I enjoy caring for people at the end? I don't mean I want them to die, because I have usually got to know them and care about them and their families, but I am really proud of the good care we give and how comfortable we make people. It is nice knowing you couldn't possibly do any more for them."

A porter told us that all his team treated the people who had recently passed away on the wards as if they were "our own nan or mum. We make sure we look after their dignity and that they are comfortable. Most of us talk to them about where they are going and explain what the mortuary will be like and that their fridge will be cold. It makes our job better if we do it properly and kindly".

End of life care

We spoke with many people who were approaching the end of their life and some of their relatives. All were extremely positive about the care and support they received at Frimley Park Hospital. People told us their symptoms were very well managed and that nothing was too much trouble for staff. We observed kind and gentle interactions between staff and patients and could see that the people we visited in their rooms were clean, comfortable and hydrated. We sat with one elderly person who was being cared for in bed, in a single room, as they were expected to die shortly. This person slid their hand out of the covers to hold our hand and said they weren't really frightened as everyone was so kind to them. They said their grandchildren had visited and bought them lovely presents that were displayed around the room. Then they showed us the bright nail polish that they said one of the night nurses had used when they gave them a manicure. They said, "I used to like dancing and parties and my nails make me smile and remember those days".

We asked numerous staff about the care and support they received when people died. Many acknowledged that it could be emotionally difficult when caring for people in their last days and hours, but all said they had excellent support and told us who they could turn to at these times. Staff mentioned their teams supporting each other, approachable and supportive ward colleagues, input from clinical nurse specialists and senior managers and the chaplaincy team. One junior nurse told us about a recent traumatic death where she had been upset after caring for the patient. They said, "One of the consultants took me to the quiet room and sat with me for ages explaining why the person suffered the symptoms they did and that they would not have been aware of the symptoms. He spent ages answering all my questions and making sure I was OK". Good staff support is essential to enable the staff to provide effective end of life care. Well cared-for staff meant that they felt strong enough to provide good care in difficult circumstances. The Kings Fund 'Point of Care Programme' recognises that engaging and supporting staff is the key to making change and improvement happen. Organisations with engaged and supported staff deliver a better patient experience and offer better-quality care. We found that the good staff support available enabled them to provide effective end of life care.

Staff across the hospital were justifiably proud of the quality of end of life care they provided; all the staff smiled easily as they went about their work. They talked about, "Loving their work" and "Really enjoying caring for elderly people". Senior managers were effusive in their praise of the whole staff group and this had enabled ownership of care quality by the whole hospital staff team.

End of life care

Are end of life care services safe?

Good

End of Life Care services at Frimley Park Hospital were safe. There was evidence of good initial care provided by nursing staff working across the trust, supported by high levels of specialist palliative care input from very well qualified and skilled nurses and doctors. Clinical staff were further supported in their roles by ancillary and administrative staff who understood the importance of their role in providing safe care to people.

Incidents

- The lead nurse reviewed incidents on and electronic reporting system and ensured that action was taken to address any issues identified relating to EOLC. All clinicians were encouraged to report any incidents to learn as an organisation.
- The EOLC steering group conducts reviewed any serious incidents. These were discussed at the next scheduled meeting. The chair of the group made direct contact with clinicians involved and ensured that any actions were disseminated promptly to all involved.
- The mortuary service reported incidents via the Surrey Pathology Service governance structure as the service worked across three trusts including Frimley Park Hospital. Any incidents were reported from the tri-Trust consortium board via Frimley Park governance system.
- We were made aware of a staffing issue that the trust had identified in the mortuary. The trust had looked at strategies for managing the service effectively whilst the situation was ongoing and had decided to suspend all post mortem examinations at the hospital until the situation was resolved. The post mortem service was outsourced to the two other trusts in the consortium for Surrey Pathology Services. This showed us that the trust was reacting appropriately to changing situations that had potential to impact on service delivery.

Cleanliness, infection control and hygiene

- The previous CQC inspection noted that the mortuary policies and guidance documents had been developed independently of the trust infection prevention and control committee. This had been addressed and we saw that the policies now had infection prevention and control input in their development and included more comprehensive guidance for staff.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or caring for people after death. We saw, for example, that a daily record was kept of mortuary fridge operating temperatures.

Environment and equipment

- The trust bed management policy stated that EOLC patients were offered side rooms; staff we spoke with confirmed this was usual practice. The palliative care team and bed management team received a daily electronic list of availability of side rooms from the infection control team so that people requiring EOLC could be prioritised. We matched the list to use of side rooms and saw that the policy was being implemented in practice.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. Fridges were lockable to reduce the risk of unauthorised access and the potential for cross infection.
- Service records were available for equipment, such as the commercial instrument washer in the mortuary. These showed that equipment was being maintained and serviced in line with the manufacturers' recommendations.
- All the people we visited who were receiving EOLC were being cared for on alternating air pressure relieving mattresses that were correctly set for their individual needs.
- In response to a Medicines and Healthcare Products Regulatory Agency (MHRA) safety alert regarding incidents involving syringe pump drivers, the trust standardised all their syringe drivers to one type with a consequent reduction in the risk of potentially harmful errors and incidents.

Medicines

- An EOLC lead pharmacist was employed to oversee and advise on the pharmacy arrangements for EOLC including providing expert advice to junior doctors on drug interactions and prescribing for patients in renal failure.
- Symptom control algorithms had been agreed and implemented to support the management of dying patients. We were shown that these were available on

the intranet and in all ward areas for staff. They included specific guidelines for prescribing in renal failure. We spoke with two junior doctors who were both aware of where to find this information.

- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. Consultants from the SPCT worked across the community and at the local hospice which improved safety and continuity of care for patients.
- The audit in 2013 of the use of EOLC medicines showed that they were used appropriately in proportionate doses with no evidence of inappropriate or rapid dose escalation.
- Medicine Administration Record sheets for individual patients receiving EOLC were clearly completed and provided evidence of compliance with the trust symptom control algorithm.
- We looked at how well ward staff were managing controlled drugs stocks. We saw that staff followed the trust policy and were managing drugs in accordance with the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

Records

- Targeted work was undertaken following the national review of the Liverpool Care Pathway (LCP) leading to the decision to withdraw it in October 2013. Prompt collaboration with relevant stakeholders led to the implementation of a new Personalised Care Plan for the Last Days of Life which was approved and introduced in October 2013. The new personalised care plans were audited in March-April 2014 and an action plan had been developed to improve practice with key recommendations.
- The Trust had a 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Committee' chaired by the Clinical Director of Surgery. The Trust was currently reviewing the DNACPR policy and had introduced a new improved sign off policy on DNACPR forms. The audit dated January 2014 showed that 100% of decisions were made by a registrar or consultant. This repeats the findings from the audit for 2012/2013 and demonstrated sustained good practice.
- An audit of DNACPR forms dated January 2014 showed 100% of forms were legible with a clear signature and printed name of the clinician completing the form. All forms except one were countersigned by a consultant. The exception was because the timing was such that the consultant was unable to countersign prior to the patient's death shortly after the decision was made.
- In 21 out of 22 cases the decision to withhold resuscitation was made in discussion with the person or their family. The exception was because the family were not contactable prior to the patient dying shortly after the decision was made.
- All cases reviewed as part of the audit dated January 2014 showed that a clear record was made in individual medical records about the reason for the DNACPR decision. We looked at 28 DNACPR forms and the medical notes for these people during the inspection visit. All showed a clear reason for the decision and identified whether the person or their family had been involved in making or agreeing that decision.
- The trust acknowledged that there was still some work to do to ensure that the good practice in the use of DNACPR decisions and forms adopted by the majority of medical teams was consistent across all specialities, particularly some surgical specialities.
- Effective recording systems in the mortuary ensure that people were correctly admitted and located within the storage area. We noted that the correct release forms were signed prior to undertakers removing people from the mortuary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place with all consent forms included in the policy. The policy included the process for consent, documentation, responsibilities for the consent process, consent training and the use of information leaflets to describe the risks and benefits. The policy included advanced decisions, lasting power of attorney's guidance, mental capacity guidance and checklist and the use of Independent Mental Capacity Advocates where appropriate. The policy outlined guidance on provisions for patients whose first language is not English including the use of an interpreter's list and language line.
- Where DNACPR forms were in place we saw that either people were involved in discussion about the decision where their capacity was clear or that an assessment of their capacity had been recorded in their medical notes

and on the DNACPR form. Where people lacked capacity family members were involved in the discussions about the limits and level of medical intervention to be provided.

- We found that there were robust consent arrangements in place for managing tissue removal after death. The Human Tissue Authority (HTA) inspected Frimley Park in November 2013 and found three minor shortfalls in practice. We saw evidence that these shortfalls were addressed in a timely manner and that practice had changed as a result of the inspection. The HTA regulate organisations that remove, store and use tissue for research, medical treatment, post-mortem examination, teaching and display in public.

Safeguarding

- Face to Face Level 1 Safeguarding adults training was provided to key groups of staff who were not clinical but who had contact with patients e.g. receptionists and domestics. Level 2 Safeguarding Adults training was provided for nursing staff of band 6 and above. Level 3 Safeguarding Adults Training was provided by an external company for senior ward sisters, Matrons and Heads of Nursing. Compliance figures, which were monitored and available for inspection, showed that the majority of staff excluding those on long term sickness absence had completed training.
- Staff we spoke with all had a sound understanding of their responsibility in relation to safeguarding adults.
- The Trust had a dedicated Adult Safeguarding lead nurse; the lead clinician was a Consultant Endocrinologist from Medicine.
- Medical Staff received training on safeguarding at induction from the Safeguarding Lead. Junior doctors that we spoke with confirmed that this had taken place. All Trust staff received a Safeguarding Awareness, Protecting Children and Adults from Abuse and Neglect staff information leaflet, with their payslip in June 2013. This leaflet was also circulated to all new staff at Trust Corporate Induction when they received training about raising concerns and were shown the Surrey Safeguarding education DVD.

Mandatory training

- The Palliative Care Team had a robust training programme for EOLC which included training for Health Care Assistants, Registered Nurses and Medical staff. Nursing programmes that they contribute to include: Mandatory Training (60 sessions a year), Preceptorship training (six sessions a year) and four EOLC Study Days for registered and non-registered staff, students also spend time with the team. Medical staff training includes mandatory training for FY1, FY2 (foundation year doctors), and an annual study day on EOLC for Frimley Park Hospital GP trainees.
- We spoke with a band 5 nurse about their preceptorship training and they told us they felt it was an excellent introduction to their career as a registered nurse. They confirmed that they had been provided with some end of life care training as part of the preceptorship and that they had booked onto a study day in a few weeks' time.

Management of deteriorating patients

- For patients where the progression of their illness was clear the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put in place to ensure that non specialist staff were aware of the best way to manage symptoms that were likely to present as part of the disease progression.
- As part of the ongoing discussion with patients and their relatives the ceiling of care was discussed and documented for patients who might respond to some treatments such as antibiotics for an acute infection but for whom it would be futile and overly invasive to offer mechanical ventilation, for example.
- It is acknowledged that if people are given the time and space to talk things through, they can be supported to find a way through their problems and enabled to make decisions. The trust had an arrangement with the local Samaritans to provide a presence in the emergency department. The Samaritans were available to all patients including people in crisis, those who had suffered major trauma and to those who were identified as end of life. Support for family members and staff was also offered. Details of the Samaritans presence and their contact phone number were publicised throughout the hospital.

Nursing staffing

- The trust End of Life Strategy and policies made it clear that EOLC was the responsibility of all staff, and was not limited to the SPCT staff and Clinical Nurse Specialists.

End of life care

- The hospital policy stated that no patient should die alone. Staff we spoke with confirmed that there were always sufficient staff to ensure that people who were very close to the end of life would have a dedicated member of staff with them at all times.
- The SPCT included a Lead Nurse, three Clinical Nurse Specialists and a band 6 EOLC Nurse. Additionally, there were also two occupational therapists, a medical secretary, a multi-disciplinary team co-ordinator and a funded complementary therapist.

Medical staffing

- Specialist consultant palliative care advice and support was available 24 hours a day seven days a week. At the moment the cover was supported via a specialist palliative care telephone advice for out of hours provided by Phyllis Tuckwell Hospice with access to consultant telephone advice via the locality on call rota.
- The Palliative Care Team MDT consisted of two Palliative Medicine Consultants. There was also a split site Specialist Registrar who works at the local hospice as well as at the Trust.
- There was a GP Trainee on the rolling rotation within Palliative Care
- The Palliative Medicine Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.
- The Consultants working across the acute hospital, the community and the local hospice allowing for improved continuity and management of patients using more than one of the services.

Major incident awareness and training

- The mortuary had a business continuity and escalation plan available for staff to reference. Staff who we spoke with were aware of this plan and knew where to locate it. The mortuary manager was able to talk us through the arrangements. This meant that should there be a sudden surge in demand for refrigerated mortuary space (such as following a major incident or utility failure) that the Trust had an agreement with local undertakers to provide additional facilities.

Are end of life care services effective?

Outstanding ☆

The trust provided outstanding, effective end of life care to patients. Statistically, it was a high performing trust in this aspect of its work by providing care that exceeded the national guidance. It was fully compliant with the Key Performance Indicators of the National Care of the Dying Audit and achieved the National Institute for Clinical Excellence (NICE) Quality Standards for End of Life Care for Adults.

EOLC services were well resourced and staff at all levels were supported to complete training in the field. For example, Clinical Nurse Specialists are supported to gain higher level qualifications in palliative care.

Feedback from patients and their relatives was positive about the quality of care and the resources available to them at the hospital. The chaplaincy arrangements and involvement in EOLC provision were exemplary and people of all faiths or none could be assured that their spiritual needs were addressed.

People we spoke with reported that their symptoms were very well managed. People who were too unwell to hold a detailed conversation appeared to be comfortable and hydrated. We observed excellent bedside care which provided comfort and reassurance to the families, as well as ensuring that people remained comfortable and peaceful in their final days.

Evidence-based care and treatment

- Frimley Park Hospital had participated in rounds 1, 2, 3 and 4 of the National Care of the Dying Audit of Hospitals (NCDAH)
- In NCDAH Round 4, Frimley Park Hospital achieved five out of seven Organisational Key Performance Indicators. We saw evidence that action plans had been implemented for the two KPIs which were not achieved. Funding had been approved to support a seven day face to face palliative care service and a dedicated board member has been appointed to the EOLC Steering Group.
- The audit's clinical KPIs measured the quality of documentation and encompassed a period (May 2013) when the Liverpool Care Pathway (LCP) use was in

decline whilst awaiting the outcome of the National Review. The trust developed Personalised Care Plans for the Dying Patient to prompt and record the care and management of dying patients and their families with a view to improving the documentation of the care delivered.

- Frimley Park Hospital had responded to the national recommendations of the Liverpool Care Pathway Review which led to the decision to withdraw it from the trust in October 2013. We saw evidence from EOLC steering group minutes that prompt collaboration with relevant stakeholders led to implementation of a new personalised care plan for the last days of life. The remaining references to LCP were removed completely from the new plan during the June 2014 revision, in line with national recommendations
- The personalised care plan for the last days of life incorporated in an innovative way, the national LCP review recommendations. It also contained revised EOLC drugs recommendations from Southern Health which were aligned to NE Hampshire and Farnham Clinical Commissioning Group guidelines to improve clinical continuity and reduce risks of errors The End of Life Care drug prescription algorithms had been updated by the palliative medicine consultants. The new plan had been audited (dated May 2014) and a draft report was provided to the inspection team. The audit was very comprehensive and identified a number of discussion and learning points which indicates a continuous cycle of improvement. These included a discussion about whether the majority of patients being known to the SPCT meant that wards were identifying and referring people very well or whether there were other people in the hospital not identified as needing EOLC who would benefit from use of the care plan.
- NICE Quality standard for end of life care for adults, Quality statement 6: Holistic support – spiritual and religious states that, "People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences". It suggests that there should be evidence of availability of local chaplaincy services in accordance with NHS chaplaincy: meeting the religious and spiritual needs of patients and staff (Department of Health 2003). We judge that the chaplaincy service at Frimley Park Hospital was particularly good at meeting the needs of people receiving EOLC. The Anglican and Methodist chaplains were supported by one of the Consultants who provided chaplaincy services for Muslim patients and a Roman Catholic priest from the local parish who visited the hospital one day a week. There was also good links to other religions, with a local Rabbi providing support to Jewish patients. The newly developed EOL Care Plans included a section to demonstrate that people's spiritual needs had been assessed and chaplains wrote in the patients' records when they had visited the patients.

Pain relief

- Effective pain control was an integral part of the delivery of effective EOLC and this was supported by the SPCT and the dedicated inpatient pain service.
- Care of the dying guidelines included guidance on prescription of anticipatory pain relief for patients at the end of life. Middle grade doctors that we spoke to could direct us to the guidance and explain how they consulted with the SPCT to ensure people had access to analgesia when they needed it.
- An audit on Prescribing at the End of Life (dated November 2013) showed the MDT documentation for prescribing decisions was good in over 90% of patients. Where the prescribing rational was not recorded, discussions with family indicated the focus was on keeping patients as comfortable as possible. 'As necessary' medication for agitation was prescribed for 97% of patients.
- The specialist palliative care team were involved in the care and prescribing for 66.7% of patients reviewed as part of the audit. All patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly; the Trust recording 100% of patients receiving drugs via a CSCI when needed compared very favourably with a national average of 85%.
- This audit also showed the amount of analgesia and sedation did increase as death approached, but made it clear that this increase was always in response to symptoms increasing.
- The Hospital Palliative Care Team carried out a review of how well the Trust complied with the NICE Clinical Guidance 140 'Use of Opioids in Palliative Care' using a gap analysis methodology and was able to demonstrate full compliance with the NICE guidance.

Nutrition and hydration

- The new Personalised Care plans included prompts to ensure patient and family views and preferences around

nutrition and hydration at the end of life were explored and addressed. We saw one person had been referred to the dietician because they had been admitted via their GP with and acutely reduced appetite and loss of weight. An urgent referral to the dieticians had been made but between the referral and the assessment the next day, the patient had been diagnosed with end stage disease and identified as rapidly approaching the end of their life. We saw that the dietician made a comprehensive assessment and added a sticker to notes to the effect that the person was receiving the maximum non-invasive nutritional support and as such no further intervention was appropriate.

Patient outcomes

- The Trust had systems that ensured that there was timely identification of people needing EOLC on admission or who moved from active treatment to palliation whilst an inpatient.
- 45% of patients identified as requiring EOLC had expert input from the Hospital Palliative Care Team.
- The Hospital Palliative Care Team's clinical effectiveness and impact on insight/discharge planning was measured using the Palliative Care Assessment tool (PACA).
- The Trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring high quality care for patients who wished to die at the hospital.
- The benefits of early intervention on the part of a palliative care network were being developed and work with other stakeholders and providers locally was being done to aim to reduce inappropriate admissions at the end of life via the emergency department or to the medical assessment unit. Work was in progress on developing a model of care where end of life decisions and specialist palliative care input was available at an earlier stage of progressive diseases such as heart failure, chronic obstructive pulmonary disease and renal failure.
- The Trust is a member of the phase 2 National Transforming End of Life Care in Acute Hospitals programme. The National Transforming End of Life care in Acute Hospitals programme was developed from this and consisted of a group of 25 acute Trusts that worked together to develop and improve the quality of EOLC in hospitals. Phase 2 is the next step in sharing good practice and working together to improve EOLC.

Competent staff

- The Palliative Care Clinical Nurse Specialist team were well qualified, with all having completed Advanced Communication Skills training, psychology Level 2 training and received monthly clinical supervision from a clinical psychologist.
- The Palliative Care CNS team are all trained in specialist palliative care, having completed their first degrees and were now pursuing their Masters in clinical practice. The Lead Nurse had a Master's degree in Advanced Clinical Practice in Palliative Care which meant that there was high levels of expertise and good understanding of current issues within the nursing team. They, and the Palliative Care Consultants, provided training and support to all grades of staff across the hospital to ensure that ward staff felt confident to deliver EOLC.
- Whilst the specialist occupational therapists were an important and integral part of the palliative care team, they were provided with line management supervision through the occupational therapy service.
- All staff had training in equality and diversity as part of their induction. Guidance was available on wards, in the chapel and multi faith room and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences.
- The preceptorship programme for newly qualified nurses was described by several of those nurses as, "Excellent", "Really, really, good preparation for practice" and "Amazing". The programme provided new nurses with two preceptors, one from their ward or speciality and another who was independent of the ward. EOLC and the essential competencies to provide care to the dying were included both formally and informally as part of the training programme.
- Both consultants working in palliative medicine had been appraised in the preceding year and were working towards revalidation in line with General Medical Council guidance and trust policy. The speciality registrar received appraisal by and education supervisor at the local hospice, as their post was a shared appointment.
- Staff told us that the Clinical Nurse Specialist for EOLC came onto wards when they had a dying patient and helped staff learn by working through care planning and ensuring staff had basic competencies such as using syringe drivers.

End of life care

- The palliative medicine consultants had completed the Qualified Educational Supervisor Programme (QESP) offered by NHS postgraduate education for Kent, Surrey and Sussex to safely provide clinical supervision to doctors

Multidisciplinary working

- Multi-disciplinary team (MDT) working was integral to the delivery of effective EOLC at Frimley Park Hospital. The records of the 26 patient records we reviewed showed us that ward areas had regular multi-disciplinary meetings to discuss and agree management plans for patients. We observed one such meeting taking place. The group were talking with relatives about the best care of a patient who was approaching the end of life and who had very little appetite. Staff were trying to explain to the patient's relatives that their loss of appetite was normal for this stage of illness and that artificial feeding was inappropriate. The relatives felt that parenteral feeding would give the patient strength and that they then might get better but came to accept that this was not the case because of the patience and repeated explanation of the medical team.
- There was a weekly MDT meeting to discuss treatment plans for new and current patients. This was attended by the chaplaincy team who then visited patients who wanted to see them and offered non-clinical and spiritual support.
- The SPCT included two occupational therapists who were key member of staff in assessing whether patients were able to be moved home to die using the rapid discharge process to ensure people were able to be cared for in their preferred place of death at the very end of their life. The Trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring high quality care for patients who wish to die at the hospital
- The Hospital Palliative Care Team worked closely with the Pain Team, the Acute Oncology Team, the site specific cancer Clinical Nurse Specialists and the non-cancer Clinical Nurse Specialists to ensure seamless care was delivered to patients. We saw evidence in people's records that the integrated approach to care improved care planning and outcomes.
- Medical staff from the SPCT worked sessions at the local hospice and in the community. This allowed for better continuity of care and provided a more standardised model of care across the local healthcare economy.
- At a strategic level, the EOLC steering group had representation from many disciplines including the palliative care consultants and nurses, an emergency department consultant and resuscitation officer, consultants from anaesthetics, orthopaedics, cardiology and elderly care, chaplains, a speech and language therapist and GP representation. Support for the group was also provided by the complaints manager, the bereavement office manager and the Heads of Nursing for cardiology, acute services and medicine. This breadth of involvement demonstrated the cross Trust commitment to developing and improving EOLC at Frimley Park Hospital. We saw the minutes of an ELOC Steering group meeting that demonstrated attendance and showed dissemination of information across the hospital.

Seven-day services

- Inpatients at Frimley Park Hospital had access to specialist palliative care input around the clock for seven days a week. NICE Quality Standard for End of Life Care for Adults (2012) statement 10 states that, "Service providers ensure that systems are in place (such as shift patterns and on-call rotas), to provide timely specialist palliative care and advice at any time of day and night for people approaching the end of life who may benefit from specialist input". Adequate medical and specialist nursing cover was available to provide a very good service level across all areas of the Trust. The current arrangement with the local hospice allows hospital staff to have access to specialist medical advice outside of normal working hours. Funding had been agreed for the staffing complement to increase by an additional 0.6 FTE Clinical Nurse Specialist from September 2014 to provide a 7 day face to face service to patients.
- Patients at Frimley Park Hospital who were receiving end of life care are seen and provided with a 'Friday Plan' that details the most recent advice of the SPCT. The plan was written on a separate form that is affixed to the front of the patient's notes so that it is readily available, if necessary.

Are end of life care services caring?

End of life care

Outstanding ☆

Staff at Frimley Park Hospital provided very compassionate EOLC to patients. One nurse summed it up when they told us, "If we don't get it right when they are dying we can never put that right for them, for their family, or for ourselves. It would be dreadful to know you could have done better and didn't".

We saw that staff were committed to providing good care to people that focussed on meeting the wider needs of the dying than the purely physical. There was good recognition of the importance of family and friends as life ended. We were told lots of stories that demonstrated the compassion and kindness that pervaded the hospital. Staff told us about weddings and funerals they had attended; they told us about sitting and singing gentle lullabies through the night when someone was at their most frightened.

We heard about large traveller families visiting and new-born great grandchildren being brought to visit.

Staff were encouraged to innovate; we saw evidence of how staff ideas had been developed and led to service improvement. An example of this was the invitation for relatives to return to the hospital after a family member had died in the emergency department to discuss how decisions were made and talk through any questions they had.

Feedback from patients was entirely positive about the care they received. An example was a night nurse painting a patient's fingernails which they were really pleased about as it made them remember their younger days.

Compassionate care

- Hospital staff demonstrated a strong commitment to empathy and enhancing the environment for dying patients and their relatives in busy hospital areas. We saw that families were encouraged to participate in care if they wish (e.g. mouth care) and that patients receiving EOLC had a communication book for families to write in.
- Family rooms were available and families and friends were permitted and encouraged to stay overnight. We asked about adaptation of care to ensure the needs of people with protected characteristics, as defined by the Equality Act 2010, were met. We were told there was no problem with gay partners or friends staying over on the same terms as any other spouse. We were given the example of a traveller woman who had a very large extended family that had died at the hospital. Staff recognised the cultural need for her to be surrounded by her family in her final hours and this was facilitated. Staff demonstrated great flexibility and an attitude of solving problems rather than listing inflexible; they were kind when considering whether a person's wishes could be met.
- We were also told about a Nepalese person for whom chanting at the bedside in their final hours was perceived as comforting by relatives. The staff had provided care in a side room and enabled the chanting to take place by minimising interruptions and explaining to staff what was happening.
- Complementary Therapy services were available for EOLC patients with a therapist being an integral part of the Hospital Palliative Care Team. This was received very favourably by patients and felt to be very beneficial by relatives we spoke with.
- The 'Nobody Dies Alone' mantra was being finalised by Director of Nursing (occasionally referred to as Chief Nurse) at the time of the inspection visit. Staff we spoke to were aware of this philosophy and told us that they always ensured that dying people had someone with them. We spoke to staff in the emergency department and were told that a member of staff would always be found to sit with someone in their final hours, if they remained in the department. A healthcare assistant told us that they had sat with people several times when it was realised the person was likely to die very shortly. They said that the family were called but that the staff made sure someone was with them all the time until the family arrived.
- The Trust provided three memorial services for relatives of patients that had died at the hospital. We were told that the initial idea had been suggested by one of the emergency department administrative staff and that this person had set up the event. There were separate services for patients who died on the intensive care unit or in the emergency department; those people cared for by the hospital palliative care team and for all other patients. We were told about the last service that was attended by about 80 people. White roses had been provided by a local supermarket retailer and people were given labels to write the names of their relative on. The hospital chaplaincy was involved in leading the service.

End of life care

- Staff in the emergency department had identified that they disliked handing over property to bereaved relatives in a carrier bag or spare cardboard box. They had introduced more suitable memorial boxes that contained a small gold coloured bag for jewellery and had space for other personal items. The box came with two small teddy bears, one for the bereaved family and one to travel with the person to the mortuary. The boxes were simple cream coloured boxes with a gold ribbon tie that demonstrated care and compassion in a very practical way.
- In the emergency department patients identified as dying were cared for in a single room and moved from a department trolley to a hospital bed to increase their comfort. There was an informal agreement amongst staff that patients for whom death was imminent should not be transferred from the department as the staff in the emergency department had already established a relationship with them, and often their relatives.
- Following a death in the emergency department, a letter was sent by a consultant and a department sister to the bereaved relatives about six weeks afterwards. This letter invited people to come back to the department and speak with the medical and nursing staff about the loss of their relative. It enabled them to ask questions and understand how and why decision were made and so reduced the risk of complicated grief reactions.

Patient understanding and involvement

- The use of a Communication booklet had been rolled out for patients and their family as part of the new EOLC documentation. This gave an additional opportunity for questions to be asked and information to be shared.
- We saw several comments books and files relating to EOLC (In the Time Garden, the Chapel and multi-faith room and on wards). All the comments we received were positive in the feedback they gave.
- Patients and families were encouraged to participate through feedback and surveys: “Famcare” audit had been done twice.
- A ‘Voices’ meeting for bereaved relatives was held in June 2014. The National Bereavement Survey (VOICES) 2012 was commissioned by the Department of Health and administered by the Office for National Statistics.
- Patients and relatives that we spoke with (and who had capacity) were able to tell us who ‘their’ consultant was and knew the name of ‘their’ nurse.
- The patient’s preferred place of care/death was explored for every patient during the weekly MDT discussion and documented on the Somerset Cancer Register.
- The Palliative Care Team attended a Constituency Meeting in November 2013 to update and involve local patients and stakeholders on the services available at the Trust for EOLC.
- There was a selection of patient information materials available to support patients and their families in understanding EOLC. We saw that these were available around the hospital.
- We observed interaction between medical teams and family members of a person who was receiving EOLC. The doctors worked hard to help the relatives understand what was happening and what the preferred plan of care was.
- We observed nursing staff caring for several people with dementia and spoke with patients being cared for alongside these patients. We saw that the staff attempted to engage with and seek the opinion of people over care decisions. They gave clear, unambiguous explanations that people could understand.
- The minutes of the EOLC Steering Group dated June 2014 show that consideration was given to having a patient attend the group but that this was felt to be inappropriate but that they were invited to a Patient Focus Group.

Emotional support

- Chaplaincy support was available 24 hours a day via an on call system. The ordained chaplains were supported in their work by 38 chaplaincy volunteers.
- A Christian service took place every Sunday in the chapel. The chaplain on duty and volunteers then visited all the wards to offer prayer and communion.
- The local Nepalese community was supported with chaplaincy by a Lama provided by the Ministry of Defence.
- We were told by several staff and the chaplains about weddings that had been conducted for people receiving EOLC at the hospital.
- Chaplains often accompanied families to the mortuary to be with them whilst they spent time with their relative. Whilst visiting the mortuary we saw this being arranged between the mortuary manager and chaplain.

End of life care

- Chaplaincy support arrangements were written into the major incident plan for the trust. This demonstrated that emotional support and spiritual care was considered important at all times.
- An End of Life Care Nurse and palliative care Clinical Nurse Specialists were employed to provide ongoing support and advice to patients and their families. They were able to signpost people to additional sources of support such as those provided by the local hospice.
- We reviewed 26 sets of medical and nursing records for patients receiving EOLC. We saw that all patients had regular assessment of their emotional condition and that, where considered necessary, antidepressant medication and anxiolytic medication was prescribed and administered.
- Families and friends, including children, were encouraged to visit and spend time with patients at all times as they approached death. We were told about a young adult patient who had suffered a serious road traffic accident and was not expected to live because of their injuries. The staff had phoned the person's spouse and encouraged them to come to the hospital with their young children so that the whole family could be together and the children would have a better understanding of what had happened. According to research by the Institute for Trauma and Stress at the New York University Child Study Centre this reduced the risk of complicated grief reactions and subsequent mental ill health.

Are end of life care services responsive?

Outstanding ☆

EOLC services at Frimley Park Hospital were very responsive to patient's individual needs and the wider needs of the local community. A commitment to ensuring equality of access and service provision was seen as underpinning the Quality improvement agenda.

We saw evidence from data that fewer people died in hospital than the national average for all Trusts. We also saw that a higher proportion of people had input from the Specialist Palliative Care Team than was the norm nationally.

The Trust also responded well to changes in public perception and national guidance. It was able to demonstrate a flexibility of service provision that resulted in adaptations to ensure that practice was in line with current best practice guidance.

Service planning and delivery to meet the needs of local people

- The palliative care service was widely embedded in all clinical areas of the hospital.
- We saw a high referral rate and high non-malignant caseload. The SPCT saw approximately 1,028 patients in 2013/14 and 51% of these were non- cancer patients; this demonstrates a good balance between cancer and non-cancer patients.
- There was a 24 hour electronic referral system in place for referrals to the Palliative Care team which ensures patients are seen and assessed in a timely way. We were able to see the effect of this on a patient who had been admitted via the emergency department overnight and who was seen by the SPCT the next morning.
- The End of Life Care Nurse did a daily ward round to review patients on the Personalised Care Plan for Dying Patient whilst offering support and informal training to the medical and nursing teams. Palliative medicine consultants also available daily to review patients and speak to carers
- There are strong links with respiratory and cardiac teams and representation from these specialities on the EOLC Steering Group.
- There was very good communication between the community and the hospital to achieve home deaths. From February 2013 to January 2014 the Trust SHMI showed that for non-elective patient admissions, the percentage of deaths occurring in hospital was 70.3 compared to a national percentage of 73. Approximately 3% more patients died in a home setting 30 days post discharge than in hospital in comparison to the national picture; showing the effectiveness of this communication.
- Further integration and 'joined up' design of services included cross sites consultant and specialist registrar posts very close links with two local Hospices at Home schemes and standardised Advance Care Plan documentation across the local CCG, hospice and the hospital.
- The Trust had an End of Life Care Strategic Plan (2009-2014) which had been adapted as national

guidance changed (such as the withdrawal of the use of the Liverpool Care Pathway due to public concerns following negative media reports). This showed us that the Trust had a clear idea of where it what it wanted to achieve but that the plan was sufficiently flexible to adapt to the changing needs of the local and wider population.

- There were 1433 deaths at FPH in 2008; in 2013 there were 1,027, a reduction of just over 28%. This reflected the proactive and effective stance that the Trust and local healthcare providers have taken on acute hospital admission at end of life. It was also linked to an effective discharge process that allowed people to be transferred home to live their final hours in their preferred place of death.
- The involvement of a consultant gastroenterologist as the lead for the DNACPR steering group and the Clinical Director for general surgery and urology as the chair of the EOLC Steering Group raised the profile of EOLC across the Trust and removed responsibility for good EOLC from the SPCT alone and made it the business of all staff.
- Equality and Diversity consideration were well embedded in staff practice and policy development at the Trust. There was an equality and diversity steering group that had representation from across the hospital. A review of the demographics of the local population had been undertaken to develop a patient profile to inform service planning and development.
- There was open visiting and free parking for the relatives of people receiving EOLC. We saw that refreshments were made available to visitors and that they were able to use the canteen facilities.

Access and flow

- There were rapid discharge protocols and processes in place that were seen to be effective in getting people to their preferred place of care prior to their death. The Rapid Discharge Pathway was revised in May 2014 and was used to support discharges
- Frimley Park Hospital worked very closely with NE Hampshire and Farnham CCG on the Electronic Palliative Care Co-ordinating System (EPaCCS) roll out of commercial software system that allowed the entire patient journey to be measured and analysed from initial telephone call, through to arrival, consultation, prescribing, internal and external referral to another department or service and closure. The system also maintained clinical continuity by automatically sending full consultation details to the patient's GP allowing patients to have a seamless experience.
- We saw that the team used the Somerset Cancer register database. The database enabled the Palliative Care Team to record activity and to link with the cancer site specific MDT outcomes. The Somerset Cancer Register collects all the information necessary to make sure that a patient is seen, diagnosed and treated as quickly as possible. The electronic register reduces duplication of information and allows for real time collection of information about a patient and ensures that their journey through the healthcare system is as smooth as possible. The database now covers 13 tumour sites, is used to collect data to support the patient pathway at the same time as meeting the national and clinical audit requirements.
- A representative of the hospital social services team attended the weekly palliative care MDT which allowed for the wider care needs of patients to be considered and addressed prior to death or discharge.
- There was a palliative care email alert system in place in real time that informed the palliative care CNS team of any emergency admissions to the emergency department of palliative care patients previously known to the team. This supported the early assessment and management of patient care and sometimes prevented the need for admission.
- Staff in the accident and emergency department had access to IBIS, a database which flagged when a person who was known to the community palliative care services was attended by the ambulance trust. These people arrived with lots of information and rapid intervention or advice from the Hospital Palliative Care team was able to significantly reduce the number of admissions. People could be treated, have improved symptom control measures put in place and returned home from the emergency department.
- Of the patients referred to the SPCT, 43.8% were discharged home and 48.6% died at the hospital.

Meeting people's individual needs

- Personalised care plans encouraged tailored care to individual patients at the end of life. These were supported by a communication book that allowed staff and relatives to share information and ask questions.

End of life care

- The Trust has an outside area reserved for the exclusive use of patients receiving EOLC and their families and friends. The Time Garden leaflet is given to Palliative Care and EOLC patients and their families and this is accessible between 08.00-20.00. The area had a well maintained and well screened garden with water features and seating. There was also a wooden cabin that allowed people to use the facility when the weather was poor and when they could not be moved from their bed. Music and refreshment facilities were available and there was a phone that could be used to contact staff, if necessary. A book was available to record people's thoughts and comments; this showed us the facility was used on a daily basis. Recent comments made included, "What a wonderful opportunity to spend time in such peaceful surroundings together – Precious memories" and, "Fantastic in the sunshine. It made my mother's final hours so peaceful".
- We noted from the comment book that the ability to spend time outside, feeling the sun and fresh air and away from the noise and hustle of a busy acute hospital was very much appreciated by the patients and their families. It enabled younger children to spend time with their dying grandparents in a softer, less intimidating environment where they would not disturb other patients. We were told about one patient who had chosen to die in the summer house, surrounded by their family. Their death was reported to be so peaceful that the family had not realised that death had occurred until a nurse came to check on the patient.
- Across the Trust we found considerable respect for the cultural, religious and spiritual preferences of patients. The Trust was proud that they had recently trained a group of eighteen interpreters from the local Nepalese community to Level 4 interpreting in conjunction with Southampton University. This allowed 60 hours a week of medical interpretation for this local community that was provided in response to feedback from patients.
- The Trust used the language line to provide interpreting services for most languages other than Nepalese. A list was also maintained of staff who were able to speak a language other than English and who were able to provide some interpreting, if necessary.
- The Trust had introduced many initiatives as part of their work to implement 'Putting People First', the National Dementia Strategy. They had convened a dementia steering group which met bi-monthly to ensure they continue to build on improving dementia care. The Dementia Strategy supported staff to provide good care to people with dementia, many of whom were approaching the end of their life. There was a dementia lead nurse and link nurses on wards and in departments as well as specific resourcing such as a dementia café and activity boxes.
- The Trust considered all complaints received and logged them against the different protected groups listed under the Equalities Act 2010. This allowed trend analysis and work to be done to improve access and services for people with particular needs.
- Specific feedback was sought from people with disabilities and action had been taken in response to this feedback. The Trust was trialling magnifying sheets for menus and had introduced Chatterboxes (an assisted listening device) for the hearing impaired, for example.
- A register of patients with special needs was maintained by the Trust. A simple system of highlighting additional needs, such as visual impairment, to staff was in use that involved using a sticker on the front of peoples' medical records. The register was used for monitoring compliance with equality legislation and for service planning.
- The hospital had both Christian chapel and a multi-faith prayer and quiet room located centrally and available to all staff, patients and visitors. In the chapel, a prayer tree had been created that allowed people to write their thoughts, hopes, fears and prayers on a leaf and hang it from the tree. Where people wanted some form of gesture but did not want to write anything ribbons were provided to tie to the branches so that they could, "Leave just a little bit of themselves in the chapel". The tree was well used and we saw that each week the leaves and ribbons were removed and placed on the altar during the weekly service. We spoke with a patient who we saw had used the chapel and written a leaf. They told us it was very comforting to be able to come and sit quietly and "gather their thoughts".
- The multi-faith room was appropriately equipped to ensure that the needs of majority religions were met.
- Facilities and guidance for staff on caring for people after their death according to their religious beliefs were available in the mortuary. The staff we spoke with were aware of the content of these guidelines.

End of life care

Learning from complaints and concerns

- The complaints office introduced a new 'end of life care' category specifically for complaints related to end of life care. The Complaints office representative attended every EOLC steering group meeting and provided a summary of complaints related to EOLC with an action plan that had been created to address shortfalls identified. Where there were concerns people were invited to meet with Trust representatives to resolve the situation locally
- There were very few complaints relating to end of life care. There was a year on year reduction in the level of complaints received by the Trust which related to EOLC. In the year 2009/2010 the last 2 quarters each had 5 complaints recorded; in the same period for 2013/2014 there were 1 and 2 complaints for Q3 and Q4, respectively.
- A member of the complaint team attended the EOLC steering group where every complaint received (both formal and informal) was discussed. The Patient Advice and Liaison Service (PALS) met with patients and helped them get answers to any questions or concerns they had. We saw an example where a meeting had been set up with the matron for the ward and the Hospital Palliative Care Team. The family had also been invited to share their experiences at the Patient Voice experience.
- During May 2014 three informal and four formal requests had been made by relatives requesting meetings to discuss the late patients cause of death in order to gain a better understanding of this. The suggestion had sometimes been made by the family GP or Coroner who emphasised the need for families to know who to contact to discuss outstanding concerns and questions. The Trust had responded by ensuring this information was given as an additional message to relatives when they attended the Bereavement office.
- There was strong evidence of learning from concerns and comments made by relatives, patients and staff. This included the EOLC side room policy being developed to address a situation where it was identified that an EOLC patient had been subject to multiple moves. The bed management system identified which people were in a side room because they were receiving EOLC and this protected them from unnecessary disruption and moves to unfamiliar wards.

Are end of life care services well-led?

Outstanding ☆

The End of Life Care Service at Frimley Park Hospital was exceptionally well led. The trust was aware of what they were doing well and areas where there were still challenges to address. We saw a flexible and adaptable service that responded effectively to national initiatives and local demand in a timely manner.

It would not be possible to deliver the quality of service we observed if leadership was ineffective. We saw local and service leadership that encouraged collaborative working and sharing of ideas and information to the benefit of dying patients and their families. All the staff we spoke with were clear that they were led by people who were approachable and supportive; they could give clear examples to demonstrate this.

Robust clinical governance arrangements provided assurance to the Board that safety was being well managed in respect of End of Life Care. We heard about the trust wide commitment to a cycle of continuous Quality Improvement and saw evidence of the positive impact this had on EOLC delivery.

Vision and strategy for this service

- Following the National Care of the Dying Audit of Hospitals (NCDAH) results, the trust developed an action plan that included appointment of a non-executive director as a Board lead for EOLC. The Trust fully met their action plan and meets all of the KPIs for the audit.
- During the year 2013-2014 the SPCT led a robust response to the 'More care, Less Pathway' review of the LCP. This resulted in the creation of a hospital policy for the care and support of dying patients, guidelines for safe prescribing, development of medical and nursing care plans and the development of new patient and carer information booklets.
- It was recognised that an expansion in the number of side rooms within the Trust would improve the experience of care for dying patients and this had been included in the Capital Expansion Plan.
- The Trust has identified Core Challenges for EOLC services for 2014-2015.

End of life care

Governance, risk management and quality measurement

- We saw a clear governance structure from ward and department level to the Board. Staff were clear about incident and statistic reporting and how this was used to inform practice improvements across the Trust.
- The EOLC Steering Group reported directly to the Clinical Governance Committee which scrutinised its work, highlighted issues and challenged their processes. An Annual report was available to the Board.
- There was a Hospital Non-executive Director with EOLC responsibilities. At the time of the inspection visit, a process was being developed for EOLC to be discussed annually at Board level.
- We also saw evidence of wider learning and response to comments such as information leaflets about the Time Garden being made more readily available. The DNACPR Steering Group had been set up in response to concerns being identified by the EOLC steering group.
- A Clinical Governance Report 2013-2014 for End of Life Care and Specialist Palliative care was available from March 2014. It was linked to the CQC Essential Standards of Quality and Safety. No specific issues were identified and much good practice was detailed.
- The Trust achieved 96% compliance with the National Cancer Peer Review Programme Specialist Palliative Care Measures in 2013. The National Peer Review Programme is a quality assurance programme that is aimed at reviewing clinical teams and services to determine their compliance against national measures, as well as the assessment of quality aspects of clinical care and treatment. The National Peer Review Programme encompasses a whole systems approach to quality and safety in relation to the patient experience and clinical outcomes and provided evidence of effective service monitoring and governance.

Leadership of service

- There was comprehensive leadership within the palliative care department with clearly defined responsibilities (Department audit lead, research lead, consultant with responsibility for developing non-malignant palliative care, lead nurse with service improvement role).
- The 2013 NHS Staff Survey showed that the percentage of staff reporting good communication between senior management and staff was 41% compared favourably to a national average of 27%. Staff also reported good levels of support from their immediate managers.
- All the staff we spoke with felt their line managers and senior managers were approachable and supportive. They were also able to name members of the SPCT team and give examples of their involvement in optimising patient care.

Culture within the service

- The 2013 NHS Staff Survey showed that the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver was, at 82%, higher than the national Trust average of 76%.
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important EOLC was and how their work impacted on the overall service.
- The Chief Executive Officer described the staff as working 'For' Frimley Park Hospital and not 'At' Frimley Park Hospital. Staff we spoke with did use this term and felt a deep sense of belonging to the organisation. One member of staff said, "I love it here, I love my job. It is like a second home to me because I have worked here for 26 years".
- We spoke to eight staff about raising concerns and whether they felt they would be listened to. They all described how they would report safeguarding concerns and went on to talk about the approachability of their manager and their team ethos that meant they would feel able to raise concerns.
- We asked the mortuary manager whether the staff working in their department felt a sense of belonging to the wider hospital team. They told us that they had lots of contact with non-mortuary staff and that there were frequent visitors such as the chaplains, porters and photographers who they got to know quite well. They were able to appreciate where their work fitted into the overall provision of outstanding EOLC services.

Public and staff engagement

- The Trust had over 16,000 Foundation Trust members and they received feedback on many issues at the quarterly Constituency meetings that were held at

different venues. We were told that the attendance at these meetings can be over 100 members. The SPCT and EOLC Lead presented an update on EOLC services at the Trust at the November 2013 meeting.

- The Trust participated in the FAMCARE surveys in 2012 and 2013 and the Lead Nurse attended the VOICES event for bereaved relatives in 2014.

Innovation, improvement and sustainability

- The Trust staff were able to provide us with numerous examples of innovative practice, some (such as the Time Garden and occupational therapists as part of the Hospital Palliative Care Team) of which are detailed in other sections of this report.
- There was evidence of the Trust embracing EOLC for non-malignant palliative care patients and they were piloting the Gold Standards Framework in Acute Hospitals.

Outpatients

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

Information about the service

Frimley Park Hospital NHS Foundation Trust (FPH) undertook nearly 400,000 outpatient appointments in 2013/14. We were told that activity had grown by 18% over the last 5 years, mainly in response to a year-on-year increase in GP referrals. The majority of outpatient activity took place on the Frimley Park Hospital site (330,000 pa) but there was also significant activity that took place in Aldershot (27,000 pa), Farnham (24,000 pa) and Fleet (17,000 pa) as well as a few other, smaller locations.

As part of this inspection we visited all outpatient areas at the main hospital site to speak with patients and relatives. We also spoke with staff and departmental managers. Information provided by the trust was reviewed and corroborated for accuracy and then used to inform our judgement. We did not look at outpatient services for children which are reported under the Children's Services section of this report.

The Trust outpatient services were complex and could be divided into those delivered on site at Frimley Park Hospital and off site, as well as those overseen by the Head of Nursing and those under other directorates or providers.

Services at Frimley Park Hospital overseen by the Head of Nursing (HON) for outpatients included

- Outpatients 1: 18 clinical rooms where predominantly surgical, dermatology, gastroenterology, immunology, urology, vascular, haematology and cancer clinics are held. The dermatology phototherapy unit was in this location. An independent GP out of hour's service was run from here in the evenings and weekends.
- Outpatient's 4: 7 rooms for medical clinics – neurology, diabetes, endocrine, thoracic, rheumatology, and anti-coagulation.
- Cardiac outpatients: 5 room cardiac clinics, alongside a clinical investigations department for non-invasive cardiac tests, attachment of monitors, exercise tests, echocardiography, pacing clinics, respiratory tests.
- ENT outpatients: 6 clinical rooms, with additional room for SALT, 2 audiology booths, and 2 audiology fitting rooms
- Fracture clinic: 4 individual rooms, with 8 cubicles, and 2 plaster rooms. This area had not been refurbished; a capital project application had been submitted to improve the environment and facilities.
- GUM (Genitourinary medicine): 3 consulting and 3 exam rooms, with additional room for microscopy and the health advisors. This area was located at the back of the hospital and can be accessed through a back entrance to the site as well as the main site entrance.
- Haematology Day unit: this is an area which delivered haematology and chemotherapy for many conditions. This department had moved some simple work out of the unit to the medical day unit to create capacity, and had a capital project application in to expand the unit.
- Radiology nurses: these nurses support the clinicians with invasive procedures within the radiology department.

Offsite overseen by the Head of nursing for outpatients

- Aldershot Centre for Health (ACFH): 12 clinical rooms on the ground floor with a variety of all specialities, 4 phlebotomy rooms, and radiology services. There was also a designated pain clinic unit with 3 clinical rooms

on the floor above. Trust nursing staff and reception staff work in the outpatient areas, radiology is a satellite for the Trust main radiology department, as is the phlebotomy - an outreach from pathology. The premises are managed through NHS property services and did not form part of the Trust.

- Brants Bridge (Bracknell): 3 clinical rooms with nurses and receptionist from the Trust. The building is owned and managed by Royal Berkshire NHS Foundation Trust (RBHT). The RBHT provided the x-ray sending images to Frimley Park Hospital. RBH did a small amount of phlebotomy with Trust nurses doing as much as possible, with all blood samples coming back the main Trust site.

Onsite overseen by Associate Director of Performance

- Medical records – a current library on site housing records for activity within the last 2 years. An offsite storage facility currently managed by a third party, housing all records with last date of activity exceeding 2 years. Medical records teams prepared all records for outpatient appointments – onsite and offsite, apart from gynaecology clinics.
- Appointments booking teams
- Receptionists covering ACFH, Brants Bridge, and all onsite areas except gynaecology,

Onsite overseen by Women's services:

- Gynaecology clinic
- Gynaecology receptionist and booking team

Onsite Eye Treatment Centre overseen by Surgical directorate & Ophthalmology matron:

- Ophthalmology clinics
- Mobile unit
- 1 clinic in a GP surgery in Sandhurst

Onsite overseen by Stroke/Elderly care G7:

- 2 clinic rooms for TIA, Stroke clinics, and day hospital attendances

Summary of findings

Overall we rated outpatients as good. Patients attending for outpatient appointments at Frimley Park Hospital and other clinic sites provided by the trust received good care. The premises were, with the exception of the fracture clinic, appropriate for the service they were providing. Where issues around capacity had been identified, the trust had responded to reduce the impact on patients.

We did identify some minor shortcomings in care practice by individual staff members, but this was not widespread.

Staff were kind, attentive and spent time ensuring patients understood what their appointment involved and what their treatment plan was. Where necessary, people were assisted to make follow-up appointments and to access the hospital transport.

The trust, generally, compared favourably with other trusts nationally in meeting waiting time and treatment targets, and in ophthalmology was a market leader, having been presented with an award as Clinical Service of the Year by the Macular Society. There was scope for a more consistent and sustained level of achievement in meeting targets and delivering an above average service.

Leadership at all levels was visible and engaged with operational staff. Staff reported feeling supported and encouraged to innovate. There was some uncertainty in response to our questions by the nurse in charge of the main outpatients department, but we accepted they had been thrust into the position by the death of a senior colleague a very short while before the inspection. The impact of the loss of a close colleague was clearly felt throughout the department but this did not impact significantly on the delivery of patient care.

The Head of Nursing for the outpatients department said, "We put patients first. We work as a team. The patient pathway through the outpatients department links with so many departments and we communicate well with them. We always look ahead and we always deliver a level of care we would expect our families to receive". Our observations found this to be true.

Outpatients

Are outpatients services safe?

Good

Frimley Park Hospital was providing safe care to patients although we saw that there remained scope for improvement in the practice of individual staff. There were effective systems in place, supported by adequate resources to enable the department to provide good quality for care to patients attending for appointments.

We spoke with staff of all grades and disciplines across the Trust outpatient areas and were told that the majority felt the department was adequately staffed to meet patients' needs. We noticed that in one clinic that there was a lone receptionist struggling to cope with sorting notes at the same time as responding to a long queue of patients who were all standing. Some of these patients had fractured limbs. The Trust was aware of concerns in this area and said, "Some departments are getting very busy and running to full capacity which is starting to cause some issues around the number of notes in reception (this has been escalated to the relevant departments/teams as there are potential solutions that may assist with this until electronic records are available)". This demonstrated the Trust understood the challenges and identified risks within the OPD; short term risk mitigation and long terms solutions were in place.

The department was clean and well maintained. Equipment was readily available and staff were trained to use it safely.

Incidents

- At the time of our inspection visit there had not been any recent clinical serious untoward incidents (SI's) in the outpatients department (OPD).
- In the ophthalmology department there was a lens implant process to prevent surgeons inserting the incorrect implant which reduced the risk of a Never Event.
- Incidents were reported as per Trust policy and via a commercial software system that enabled incident reports to be submitted from wards and departments. They were reviewed at the clinical risk meeting, clinical governance meetings in the medical directorate, and also at departmental level. Incidents were also documented in the annual clinical governance report
- We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns in a timely manner.
- We were told about an incident reported in the previous year where subsequent improvements were made. The incident related to Information Governance. A confidential waste bag that went missing overnight. The building and cleaning staff from the third party organisation involved were included in the review by the Frimley Park Hospital Information Governance lead. A change of practice across the Trust had resulted in staff locking all confidential waste bags in a locked room within the locked department overnight. This reduced the risk of the loss of personal confidential information and demonstrated learning from incidents.
- There was evidence that the Trust learnt from incidents and that effective action plans were created to address any issues identified. We were given the example of a risk identified in a phototherapy unit following cleaning of a tube which broke. Funding was approved for a Perspex cover that reduced the future risk to staff and patients. The Trust also replaced another machine with the most up to date machine, which had additional safety features and reduced treatment times
- We saw that staff were encouraged to report incidents of misfiling, escalate immediately to medical records if notes were missing for clinics. A printout of the incidents for the preceding 3 months showed us that this happened in practice and that incidents were reported.
- The OPD matron held meetings at 8.00am every morning where relevant learning and information from incidents and complaints were discussed and shared. We heard that there had been a change of practice when it was found that doctors were calling patients into clinic rooms without appropriate identity check. The department practice was changed so that nurses double checked the correct person was being seen.

Cleanliness, infection control and hygiene

- There were hand hygiene, 'Bare below the Elbow', and 'Saving Lives' audits undertaken which demonstrated staff were compliant with best practice guidance. These were done for each clinical area, and documented in the annual clinical governance report. The latest clinical governance report indicated a few areas that had not submitted information for some months, this was looked into by the sister in charge of the areas concerned and immediately rectified.

- Staff working in the OPD had a good understanding of responsibilities in relation to cleaning and infection prevention and control. However, clinical staff were not involved in the cleaning audits and the cleaning audit scores were not displayed in the department.
- Clinical areas were monitored for cleanliness by the housekeeping team and results displayed on notice boards in the department. However the cleaning schedules were not displayed and senior nurses in the department were unsure about this. Housekeeping staff could be called between scheduled times to carry out additional cleaning, where staff felt it was necessary.
- The OPD was in use 24 hours a day as the premises were used by the Out of Hours GP service overnight. The trust had arranged for twice daily cleaning and additional lavatory checks to ensure the area was clean despite heavy use.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place and completed to provide assurance that this was done. The level of compliance with equipment cleaning guidance was audited by area and the results collated. The Outpatients Clinical Governance Report (2014) showed that all areas had 100% compliance except x-ray who had not returned data due to staff shortages.
- Patient perception of hospital cleanliness was monitored by the use of patient questionnaires for each outpatient area, including off site clinic locations. The published results showed that 100% of patients thought the department was at least clean with the majority saying the hospital was very clean.
- Examination couches were checked regularly, and replacement sections ordered and fitted if any tears were found. The equipment that we saw was in good repair but also noted that the green labels the Trust used to indicate that equipment had been cleaned were not always used and this risked leaving staff uncertain as to which equipment was cleaned and ready for use. We saw that some clinical storage trolleys were not clean.
- The overwhelming majority of staff we observed in the OPD were complying with the Trust policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows. We did, however, see one middle grade doctor leave the clinic room they had been working in wearing a surgical gown, hat and mask. The senior nurse in the department was asked about this but did not respond appropriately and so the inspector spoke directly to the doctor about the inappropriate use of PPE and the potential risks this posed.
- Our observations were corroborated by the findings of audits reported in the Outpatients Clinical Governance Report (2014) which showed good compliance with the hand hygiene policy and bare Below the Elbows policies in most outpatient areas. We observed staff in the fracture clinic washing their hands in accordance with the guidance.
- An extract from the patient survey dated July 2014 showed that 84.6% of patients completing the survey felt the department was very clean. 100% of patients thought the department was at least clean.

Environment and equipment

- All mobile electrical equipment had current Portable Appliance Testing (PAT) certification.
- All equipment in the OPD had a process for updating and maintaining contracts with external providers for specialist equipment. A register was kept of the contract arrangements.
- We saw that the resuscitation trolley was checked and maintained ready for use in an emergency.
- From observation in the OPD we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacements were provided, when necessary.
- We looked at rooms that were used for treatment and found that they complied with the guidance on the safe use of lasers. Personal Protective equipment such as appropriate goggles was available, the machine was locked when not in use and access to the room was restricted when treatment was taking place. Local rules were in place and a Laser Protection Supervisor was appointed by the Trust. The annual laser protection review supported our findings.
- The environment was well maintained and there were no obvious hazards such as worn flooring.
- Staff working in the fracture clinic had access to equipment such as a glucometer and treatment kit for people experiencing diabetic hypoglycaemia in the department.

Medicines

- Medicines were stored in locked cupboards. All outpatient clinic areas had a minimum of 1 registered nurse on duty during clinic opening hours and they

signed for the keys for that area. We did observe that one medicine cupboard that was used by ophthalmology was left unlocked; this was in a staff area so the risk of unauthorised access was reduced.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open.
- Annual medicines storage audits were undertaken. The results were positive and showed staff followed medicines storage policies.
- On site and external areas which used FP10s (prescription pads) such as satellite clinics and the Out of Hours Service used a recording mechanism for the prescription pad to reduce the risks associated with loss and theft. In the main OPD hospital prescription pads were used that could only be taken to the hospital pharmacy.
- Pharmacy staff reinforced instructions and information to patients when they collected their prescriptions following a clinic consultation. Many of the specialist nurses focussed on information about medications as part of their consultations, and on the advice/telephone help lines that they ran for patients.
- We found that the safe disposal of medicines was poorly understood by staff working in the OPD. We saw medicines in a sharps disposal bin in a (locked) sluice room.

Records

- The on-site Medical records Library held all patient records for patients currently receiving treatment or who had attended the hospital within the last two years. Patients who had not attended the hospital within the last two years had their records removed from the current onsite library and held in the offsite library which was managed by an external third party company. The Medical Record Library was open 24 hours per day seven days per week, including Bank Holidays, to support emergency retrievals, requests and returns of the Trust's medical records.
- The onsite medical records library was not a closed library however, access was controlled. Staff were approved for access via staff swipe cards authorised by the Medical Records Manager and Security. Staff were also able to sign in and out of the department in order to retrieve or return records. The offsite records library was not accessible to staff other than by approved medical records staff and staff managed by the offsite provider. Confidentiality statements had been signed by these staff.
- Guidelines around the correct and appropriate filing of patient paperwork including how records need to be reduced in volume once they reached the maximum 4cm in size had been distributed to all staff. There was an ongoing awareness programme that was monitored by the Medical Records Committee. The incidents reported in this last year by the outpatients staff had reduced compared with previous years following this Trust awareness programme.
- When records were prepared for clinic, any incorrect paperwork found in the record, was removed and an incident form was completed. The paperwork and correct patient record were forwarded to the relevant staff member or area where paperwork was created so that all patient paperwork could be checked and filed correctly.
- Patient records were tracked on the Patient Administration System in order to ensure records were easily locatable. The Trust policy stated that it was every staff member's responsibility to ensure that patient records were tracked correctly as soon as the record was moved, in order to reflect the correct location of the record. This ensured that records are retrievable when needed.
- Records were retained in line with Record Retention Schedule Guidelines. At the time of the inspection, an audit was underway at the offsite storage facility which was ensuring that all records were retained by year of expected destruction and that those that had exceeded the timescales were destroyed in a secure manner and documented accordingly.
- We were told that records may not be available at point of care due to various reasons (for example, records are offsite after an outpatient attendance or records have not been locatable and are being looked for). When this occurred, the medical record preparation teams collated all available paperwork held on Patient Centre into a paper pack which was sent up to the clinic appointment so that the patient could be seen. The agreed process was that for any patient record which had not been available for 3 patient attendances, a temporary set of notes was agreed by the Medical Records Manager or deputy and made up accordingly. These temporary records were logged and monitored so

that once the original had been located; they could be merged to ensure one complete patient record. We were assured by OPD staff that this was a rare occurrence and that notes were usually available.
- Microfilmed patient records were still held in the library. When documentation from these records was required, the relevant paperwork was reconstituted into the paper patient record. It was expected that these records would be aligned with the main patient record at the time of scanning the paper record into the Electronic Document Management System (EDMS).
- We observed a clinic system whereby nurses piled sets of notes on a trolley for each clinic. These were placed face down to protect confidentiality and we were assured a nurse was always present which protected against unauthorised reading of the records. This workaround was less than ideal but we were told by nurses that they were reluctant to put notes in clinic rooms until the patient was called as the doctors fiddled around and messed up the order.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Trust had robust consent procedures for patients undergoing elective procedures.
- Staff had completed training, appropriate to their role and grade, in the Mental Capacity Act 2005 and the impact of this on their work. They had also completed training in Deprivation of Liberty Safeguards. This was up to level 3 for some staff. We asked a senior nurse about situations when this training had been put to use in the OPD but they could think of any examples.

Safeguarding

- Outpatients' staff were encouraged to contact the safeguarding lead if they have any concerns about patients. Staff assured us they knew who the Trust safeguarding lead was and how to contact them.
- Staff working in the OPD had completed the mandatory safeguarding training. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the Trust safeguarding policies on the intranet.
- The OPD matron was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- The Trust had a chaperone policy that was followed by the OPD staff.
- The Trust had a whistleblowing policy that was known to staff working in the OPD. They told us that they would feel happy using this policy to raise concerns if they felt it was necessary.

Mandatory training

- The Practice Development Sister linked with the Head of Departments to ensure that staff were released to complete mandatory training. Statistical information relating to mandatory training was available to the inspection team and provided assurance that staff were completing training.
- An induction programme was in place for all new staff, clinical and non-clinical.

Management of deteriorating patients

- The National Institute for Clinical Excellence (NICE) guidance CG50 'Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital' provides guidance on Identifying patients whose clinical condition is deteriorating or is at risk of deterioration and cites staff training and clear assessment processes as key to positive patient outcomes. Staff were trained to use the Medical Early Trigger (MET) scoring system to assist in identifying patients at risk of sudden deterioration in their condition. If a patient became unwell in the OPD, they were taken to the emergency department for full assessment and treatment. Staff were able to talk about and demonstrate a good knowledge of the Trust emergency procedures.
- OPD staff are the team that respond to MET calls and emergency calls in the main reception and entrance areas of the Trust. The Trust had clear policies and guidance in place for the management of medical emergencies.
- We witnessed two situations where patients became unexpectedly unwell in the OPD. In both cases, the staff managed the incidents competently and in line with Trust policy.
- Staff working in the OPD had completed Basic Life Support training, as a minimum. The exception to this was staff that had been off sick for an extended period. Sisters in the OPD were being trained to Intermediate Life Support level.

Nursing staffing

- A consultation review of the main OPD staff was undertaken in 2013. This led to better cover at the

beginning and end of the day (which was identified as needed because of due to increasing number of clinics). Earlier starts and later finishes were also introduced in order to maximise the off duty roster. Most staff now worked longer days, with more days off or half shifts; this had resulted in less need for staff to stay late, and accrue time owing.

- The OPD sisters were encouraged to link and review staffing levels across all Trust sites to ensure safe and appropriate levels for the clinics running on any session. Staff worked across several areas to share good practice which also helped provide a consistent level of care.
- There was a minimum staffing level of 1 trained nurse and 1 healthcare support worker in outpatients departments from 8 am until after the last patient left (usually 6pm). Rosters showed that some sessions had up to 16 staff depending on the clinics running, nursing assistance and chaperoning required. The Trust reported that the nursing team was due to be at full establishment by 1 September 2014. The current band 8 OPD matron was in an 'acting up' role from her substantive band 7 post following the recent death of the permanent matron; no decision had been made as to whether the post would be advertised as a band 7 or a band 8 post. The OPD had a higher ratio of trained nurse to healthcare support workers when compared to the wards; this reflected the nature of the work undertaken in the department.
- Off duty and annual leave was planned to ensure a senior member of staff (band 6 or above) was available on each site for all sessions (e.g. Aldershot Centre for Health, Brants Bridge Centre in Bracknell and Frimley Park Hospital) to provide leadership and accountability.
- Nurses from the OPD staffed other areas not usually considered as part of the department such as the discharge lounge. Where this was the case, nursing staffing levels were amended to cope with the changing demands for example, the chemotherapy staffing unit had increased as services and demands had changed when the hours the department was open extended two years ago
- There were ten nurses working in the breast clinic to provide chaperones for each doctor as well as allowing for three nurses in the department who were not working with a particular doctor. Three doctors that we spoke confirmed that chaperone nurses were always available.
- We were told that increases in the complexity and numbers clinical investigations taking place within the OPD had necessitated increased staffing over the last few years as services have developed. The Trust had introduced introduction and retention mechanisms as this is considered a group of staff that is hard to recruit. For example, a new respiratory physiologist post had been created following changes to new equipment and an increased requirement for the tests by the respiratory team. The OPD Clinical Governance Report (2014) showed, for example, that since 2007/8 the number of Echocardiographs being provided had increased by 20% and the number of lung function tests had increased by 103%.
- Some agency staff were working in the department when we visited to maintain reasonable waiting times and cope with new services commencing. We were told that there were limited number of bank nurses who could work in the OPD as they had to have specific competencies to undertake the role. Where necessary staff employed on part-time contract worked additional hours to make up any shortfall.
- The Trust website told us that they spent proportionately less on agency staff than the 2011/12 national and local average. However, agency spend totalled £7.8m during 2013/14, which as a percentage of the salary bill represented 4.9%, which is higher than the 2.8% reported 2012/13. The trust had established a steering group to better understand the reasons and reduce spending. This told us that the Trust was ensuring adequate staffing levels to respond to demand and ensure patient safety but also considered the demand more deeply so that longer term solutions could be found.
- Staff working in the fracture clinic told us that it was rare to have less than the planned number of staff.

Medical staffing

- The Trust senior management told us that they appointed new medical staff following reviews by the directorates and approval from the Board when demand for services increase. Several specialities were seeing continuing increase in demand, and in order to meet 18 week targets, additional clinics were being run with new medical staff appointed for sustainability.
- An independent Out of Hours GP service runs out of the Frimley Park Hospital OPD and could be accessed via the 111 telephone helpline.

Outpatients

- Specialist clinics were properly resourced. In the genitourinary medicine (GUM) clinic, for example, there were two whole time equivalent (WTE) consultants providing care for the local population of over 400,000 people. This was above the nationally recommended level of 2WTE consultants per 250,000 patients. Consultants working in the clinic were supported by additional staff grade, military trainee and GP trainee doctors.

Major incident awareness and training

- Staff spoken to were aware of the Hospital Major Incident Plan. We were told that in the event of such an incident the OPD1 clinic would become the press office with the Ear, Nose and Throat clinic becoming the Gold Command Room. OPD staff would be redeployed to provide direct patient care. There had not been any recent major incidents but we were told that there were practice scenarios, "occasionally". Staff spoken to could not remember the last practice specifically.
- The Major Incident Plan was available on the intranet.

Non clinical Staffing

- Medical secretaries worked within the appropriate directorates, with co-ordinators managing a group of staff. Medical secretary co-ordinators worked with staff to review processes for ways of working in offices and adapting to new technology, and improving efficiencies, encouraging teamwork and cross cover for colleagues planned and unplanned leave.
- The Trust management told us that they endeavoured to achieve a 5 day letter turn around, with co-ordinators monitoring sub-speciality departments weekly to monitor status, diverting help as required to address any backlogs.
- Appointment department and medical records were managed by the Associate Director for Performance. Reviews of staffing levels had led to increased staffing levels in both departments over the past two years.

Are outpatients services effective?

Good

The Trust provided an effective service that was based on national good practice guidance and evidence based services. There were good examples of innovation, such as the Fast Track Macular Referral process that had a really positive impact on outcomes for patients.

Waiting times against the national targets were at least in line with expectations and generally better than the national average.

Staff were competent and supported to provide a good quality service to patients. There were adequate numbers of staff employed and we saw that where demand increased significantly additional staff were employed.

Frimley park Hospital NHS Foundation Trust had already begun to offer a seven day a week outpatient service in some specialities and was looking to increase this to cope with increasing demand. Saturday clinics were well received by patients with low rates of non-attendance.

Evidence-based care and treatment

- Several specialities such as urology, cardiology, dermatology and breast surgery had One-Stop clinics. The Trust told us that they were currently looking to expand the number of One-Stop Clinics in as patients had expressed this as their preference.
- We saw that appointment letters explained to patients that their appointment may take a few hours and explained that the visit might involve tests and/ or treatments. We saw that OPD staff kept patients up to date on how the clinics were running, the reason for any delays and helped them through the clinic pathway.
- The Two week wait timescale for patients with urgent conditions such as cancer and heart disease was implemented to ensure patients are able to see a specialist more quickly.
- We looked at the 'Two week wait report' for the Trust for appointments during May 2014 which showed the Trust was performing above their own targets in all specialities except for lung and skin. In seven of the 16 specialities included in the report all first appointments

were within the two week wait period. Of the 689 patients referred under the Two Week Wait rule across the Trust, 95% were seen in this period against a target of 93%.

- Adherence with NICE guidelines was monitored in the relevant directorate clinical governance meetings. Some specialities were working towards meeting best practice guidelines and tariff requirements. The action log from the OPD Steering Group showed us that due consideration was given to changes to guidance and the impact tis had on service delivery. The entry dated March 2014 showed that staff were monitoring whether there was any impact on the phlebotomy service when NICE guidance changed and required patients to have blood tests prior to having magnetic resonance imaging (MRI) scans with contrast.
- The Frimley Park Hospital GUM Clinic report for Quarter 1 2014/15 showed us whether the Trust was meeting the British Association for Sexual Health and HIV guidelines. Overall the trust was performing well with some performance indicators exceeding the standards (such as 100% of high risk patients being offered vaccination and 99% of walk-in patients being seen within 2 hours). However, the standards recommend that all patients are offered an appointment within 48 hours of first contacting the service. The GUM service at the Trust failed to meet this standard with a Q4 average of 71% of patients being seen within this time which was significantly below their target of 98%.

Patient outcomes

- A 'Palpitations Project' had been set up to allow GPs to make direct referrals to the clinical investigations department at the hospital for cardiac monitoring. Data in the Clinical Governance report 2014 showed that over 300 patients had been referred for a mix of 24 ECG and seven day event monitoring during 2013/2014. This allowed patients swifter access to investigations and consequent treatment, if necessary. It also had a positive impact on costs and effective use of clinic capacity.
- The outpatient waiting list grew in March 2014 despite the 12% increase in outpatient activity against the same period last year. Even though outpatient activity increased compared to last year it still didn't keep pace with the increase in referrals, hence the increase in total waiting list. The number of outpatient 'long waiters' increased in March 2014 to 2694 which was the highest monthly number year to date.
- The Outpatients Performance Dashboard for the year 2013/2014 showed improvement against some key performance indicators over time and allowed for trends to be identified. For example, the DNA rate had fallen from a high of 6.7% in September 2013 to 5.7% in March 2014. The number of patient feedback questionnaires received had increased significantly from one or two a month in early 2013 to 251 in March 2014.

Competent staff

- We saw that the Trust employed many specialist nurses covering most sub-specialities. There were nurse-led clinics alongside medical colleagues providing care for patients with hepatitis, Inflammatory Bowel Disease, Multiple Sclerosis, Epilepsy, skin conditions and diabetes. There were also nurse led clinics for pain, tissue viability, ophthalmology, respiratory care and sleep apnoea. There was a dedicated nurse led clinic for peripherally inserted central catheters where people needed chemotherapy or other long term intravenous drugs. Many of the clinics were offered on all sites to improve easy access for patients.
- Specialist nurses told us they attended national forums and regional meetings to share good practice. Many were doing courses linked to their specialist areas of as part of degree courses.
- We saw from staff files that staff had completed training in the use of medical devices that they used to provide care and treatment.
- OPD staff were encouraged to attend the Trust Skill Blitz days that were run by the Practice Development Nurse and which took place every two months. Recent sessions had included developing skills needed to care for a person with dementia and communication skills.
- Training needs were discussed at staff members' appraisals. Some staff told us about additional specialist courses or sponsored degrees. The department bid for funding for specialist nurse training funds. A list was available in the OPD which demonstrated all staff were up to date with their appraisals, except where people were on long term sick leave.
- The Haematology Day Unit provided in-house study days for staff on the safe handling and storage of

chemotherapy drugs. All staff working in the unit had completed the course or were booked to do it shortly. The Lead chemotherapy nurse linked with staff in other local trusts to produce guidelines and policies. These were then disseminated to Frimley Park Hospital staff.

Facilities

- The fracture clinic premises accommodation was cramped and not ideal for a busy clinic; staff felt that this impacted negatively on care, heightened tension and meant that they had to work in close physical contact with each other**.** There were areas where plaster had been exposed. We saw evidence that a refurbishment was planned but staff did not seem aware of this.

Multidisciplinary working

- Many clinics had multi-disciplinary (MDT) meetings, particularly the cancer related specialities, where the team agreed and planned the care for patients and decided which clinician would be seeing the patient in clinic to explain the plan to them. We saw, for example that a member of staff from the OPD attended the breast care MDT.
- We saw and were told about a number of other examples of where joint clinics were provided. These included the orthopaedic team which had physiotherapists involved in clinics, the diabetic service having have podiatrists and dieticians working in clinics alongside the consultants and diabetes nurse specialists.
- There was a joint diabetes and antenatal clinic each week to ensure the best possible outcome for pregnant women with diabetes and their babies.
- Macmillan nurses attended the joint cancer clinics such as lung and breast clinics. These specialist nurses are funded for the first three years by the Macmillan charity and thereafter by the Trust. They specialise in cancer and palliative care, providing support and information to people with cancer, and their families, friends and carers, from the point of diagnosis onwards.
- We were told that the Trust OPD staff worked collaboratively with community services to the benefit of patients. There was evidence of liaison over individual wound care and copies of letters relating to patients were faxed to the community nurses.

Seven-day services

- As the Trust moves towards seven day working for inpatient care they had identified that there may be a consequential impact on outpatient care delivery. Work was already underway in the Outpatient Operational Group to identify where the service requirements will need to adapt to deliver outpatient services into the evening or weekends. For example there is likely to be an impact on radiology and pharmacy services.
- Some additional clinics were run at the weekends; staff were monitoring how these are received by patients. The appointments staff reported that they were having no difficulty getting patients to come at weekends and that the number of patients failing to keep appointments appeared to be low.
- The fracture clinic provided a seven day service with support from physiotherapists during the evenings.
- The department had audited how many patients needed blood samples taken for testing outside of usual clinic hours to support a bid for an increase in phlebotomy staff hours. A recruitment process had begun but it was acknowledged that this had not had a significant impact on the service at the time of the inspection visit.

Are outpatients services caring?

Good

We saw very caring and compassionate care delivered by all grades and disciplines of staff working at Frimley Park Hospital. Staff offered assistance without waiting to be asked. Feedback from the GUM clinic was particularly positive in terms of patients feeling they were well supported and cared for.

Staff worked hard to ensure patients understood what their appointment and treatment involved. Real time feedback was obtained via an electronic survey system and staff also obtained informal feedback when in conversation with patients.

Compassionate care

- The Trust told us that Staff were encouraged to follow the trust values, with positive attitudes and customer

care to patients and colleagues. We observed that this happened in practice. One of the strengths of the service in the OPD was the quality of interaction between staff and patients.

- We observed staff dealing calmly and kindly with a patient who was having a panic attack. The staff found the patient a seating a quiet area and provided verbal reassurance whilst checking their vital signs.
- We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if the needed assistance and pointing people in the right direction.
- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to in the reception area and maintained eye contact when conversing.
- Staff knocked on doors and waited for a response before entering.
- We saw one situation where a patient and their spouse were very anxious about their transport booking. Staff listened to their concerns and walked through to the ambulance booking desk with them to explain what the issues were to transport staff.
- Feedback from a patient using the GUM clinic said that the patient was, “Greeted with a warm smile and a welcoming Hello by a lovely lady. The whole running and atmosphere was very smooth and relaxing and I felt very welcomed!” Another patient wrote, “How can I ever forget you letting me cry on your shoulder and you hugging me with full of affection. It helped me overcome my pain and fear!”
- One patient had written to staff to say,” Staff X had gone above and beyond the level of care that I could ever reasonably expect them to give me. I have experienced a traumatic event in my life and they listened to me (many times0 and not once made me feel like and inconvenience. In my opinion this is priceless”.

Patient understanding and involvement

- Monthly survey for each area via a tablet, providing instant data (50 per month, 25 for 2 smaller areas), which aggregated provides a wide trust patient perspective for all on and off site clinic locations of around 300-500 per month. This provides immediate feedback which can be used by departments to improve care delivery. These are discussed at department level, the outpatient operational group and also the meeting held by the HON with Fleet and Farnham
- We saw copies of letters sent to patients prior to appointments. These showed is that people received appropriate details and explanations about when and where the appointment was as well as details about any essential preparation such as fasting times.
- The trust is in the process of implementing friends and family in the outpatient setting
- An extract from the patient survey dated July 2014 showed that 94.9 % of patients felt that they had been afforded privacy when discussing their treatment.
- Feedback from the GUM clinic showed that patients felt that staff had explained things thoroughly, “in a highly informative way”.
- The fracture clinic was cramped and cubicles were divided by curtains which meant there was no auditory privacy for patients; we could hear the conversations taking place with individual patients and between staff.
- We observed medical staff showing patients their x-rays and discussing what they showed so that the patient had a better understanding of their condition. We also saw medical staff assisting patients, giving directions and interacting with patients outside of their actual appointment.

Emotional support

- Macmillan nurses provided practical and emotional support in the cancer clinics and to patients on their pathways of care. Macmillan information boards displayed in departments gave advice and signposted people to services.
- The chaplaincy team told us that they made occasional visits to the outpatient areas and would always attend, if requested.

Are outpatients services responsive?

Outstanding ☆

The Trust was very responsive when planning the service to meet the needs of local people. Effective consultation allowed the service design to meet the needs of local communities and staff groups. We saw good ownership of the care and treatment they delivered by staff of all grades.

Outpatients

A pro-active stance was taken in addressing issues that impacted on care delivery, such as a developing a robust policy to monitor and reduce non-attendance at hospital appointments. In general, resources and facilities were good and met the needs of people attending the department. The outpatient department was aiming to provide care closer to home for patients to provide a more convenient location for patients to have their treatment.

The outpatients department had developed the Fast Track macular service in conjunction with patient views and research and development. This was recognised by other providers both nationally and internationally as a service they visited to learn from and share best practice.

The Trust had a low level of patients who failed to attend with a 'Did Not Attend' (DNA) rate (5.8%). This was continually monitored to enable adaptations to be made to minimise wastage of resources.

The level of complaints received from the OPD was low and showed a sustained reduction over time. Staff attempted to address any concerns raised by patients at first point of contact and this resulted in few formal complaints.

Service planning and delivery to meet the needs of local people

- Most sub-specialities provided clinics in all locations used by the Trust which enabled people to attend appointments closer to their homes and reduced demand on the main site facilities. The exception to this was where specialist clinics required particular equipment that was only available on one site. Off-site clinics were fun at across North Hampshire, Surrey and Berkshire.
- The hospital provided joint clinics with some tertiary care providers of very specialised services such as cardio-thoracic surgery and maxillofacial surgery.
- The Trust had a low level of patients who failed to attend with a 'Did Not Attend' (DNA) rate (5.8%). This was continually monitored to enable adaptations to be made to minimise wastage of resources. For example, texting had been used for several years and there were plans to get more explicit consent for texting and mobile numbers in the next phase of self-service check- in. All decisions regarding action following a failure to attend were made by clinicians based on the care they felt people needed.
- The Trust could demonstrate that work with inpatient services on areas which might impact on the outpatient area had was taking place. We saw a proactive rather than reactive approach to managing the service such as staff adapting the 'SBAR' tool for outpatient areas. The NHS Institute for Innovation and Improvement developed the SBAR tool is an easy to remember mechanism that can be used to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help you to develop teamwork and foster a culture of patient safety.
- Transport was acknowledged as an issue by the Trust. Arrangements had been put in place to mitigate some of the problems with the provider ambulance trust delivering the service to an agreed standard. We were told about a Transport Group that had been established with Executive input to improve this aspect of the service. Figures were collected from the discharge lounge and patient waiting area to enable the trust to challenge the length of time patients waited to be collected by the transport provider. Wherever possible, nursing staff ensure that patients using hospital transport were seen quickly to minimise delays in their return journey.
- The Trust had a 'pay on foot' multi-storey care park for visitor use, opposite the main entrance. We were told by the Trust that this was a constant issue with patients but we noted that none of the inspection team had any problem finding spaces. There was a set charge for a single outpatient appointment, irrespective of the length of time the patient was at the hospital.
- Patients attending for outpatients and other visitors had access to a volunteer run café, a shop and drinks machines. Drinking water dispensers were sited around the hospital.
- The department was clearly signposted. Information such as clinic access and contact details was sent to patients prior to their appointment.
- The Head of Nursing told us that a specialist designer had been employed when the OPD1 had been refurbished. They advised on lighting and colours to promote calmness and wellbeing. They ideas were then used when updating other areas of the department.
- The Fast Track Macular Service was set up at Frimley Park Hospital in 2005 providing care and treatment to approximately 1.3 million people. Patients were examined by an optometrist in the community who send a direct facsimile referral to the central

co-ordinator. Patients were then seen within a week and offered photodynamic therapy (PDT) within a week. The fast track referral process was shown to reduce the speed of referral from a mean of 42 days to 10 days. The one stop clinic allowed for a range of diagnostic testing, clinical assessment and information about treatment options to be delivered in a single OPD visit. The service had positive outcomes for patients which resulted in a discontinuation of treatment rate of 21.7% compared to 22% in clinical trials. The four year results were among the best in the country.

- The Fast Track macular service was developed in conjunction with patient views and this was recognised by other providers both nationally and internationally as a service they visited to learn from and share best practice.

Access and flow

- The Trust had recognised capacity 'hotspots' (such as ophthalmology where there was significant increased demand due to changes in NICE guidance and where macular service was very popular as it provided a one stop clinic, which provided care closer to home). The Trust had consulted and looked at long term sustainability solutions which had resulted in agreement to employ an additional locum from October 2014 with a permanent consultant post being funded from April 2015.
- Another area identified by the Trust as a 'hotspot' was the Ear, Nose and Throat (ENT) service. The trust responded to increased demand by providing a Saturday 'megaclinic' where 5 ENT specialist doctors saw up to 150 patients on one day.
- All clinic templates were reviewed as an ongoing process with appointment space available for new routine, new urgent and follow up visits. Clinicians were able to look ahead and make changes during their clinic. For example, they were able to overbook a clinic up to 6 weeks ahead if they needed to see a specific patient for clinical reason; a note on the template allowed administrative staff to see what the clinician wanted.
- The monthly National Statistics on NHS Consultant-led Referral to Treatment (RTT) waiting times were released on 20th June 2013 according to the arrangements approved by the UK Statistics Authority. During April 2013, 91.6% of admitted patients and 97.2% of non-admitted patients started treatment within 18 weeks. We were provided with an RTT report by speciality for the preceding year which showed that the Trust was working just above these average figures for admitted patients with the year average across all specialities at the Trust for non-admitted patients being 97.4%. The Trust RTT for admitted patients was marginally below the national average with 89.8% of patients starting treatment within 18 weeks. The national average for patients waiting to start treatment (incomplete pathways) at the end of April 2013 was 94.5% were waiting within 18 weeks. The Trust was reported the same figure of 94.5% of patients awaiting treatment who were within the 18 week target.
- At Frimley Park Hospital NHS Foundation Trust the18 week Consultant Referral to Treatment Waiting Times (RTT) weekly group reviewed trends of referrals, capacity planning, and meeting 18 week targets.
- Where clinicians were late for clinic there was a process to locate them and an escalation process to senior managers should there be further issues. At department level, waiting times in the actual clinics waiting areas were monitored and escalated to the relevant managers. If it was evident that that delays were a common occurrence in a specific area, then staff reviewed the capacity and running of the clinic.
- If there were issues with delays that involved other departments these were communicated to the relevant managers. For example, there was an issue at the Fleet site with the x-ray service; an audit was undertaken and changes were made to processes to improve patient flow.
- The Clinical Investigations Department had a dedicated porter to assist patients in getting to and from the department. This portering service enabled inpatients to be brought to the department at an appropriate time to improve the efficiency and smooth running of the department.

Meeting people's individual needs

- Frimley Park Hospital NHS Foundation Trust was one of only a few trusts nationally where the haematology day unit had been adopted by the cancer charity 'Macmillan' due to the high standard of service provided. Macmillan nurses arranged to see patients before the treatment started and also called patients a few days after the first therapy to support the patient further and check for any side effects.

Outpatients

- Chaperoning arrangements were in place for those patients that requested it; nursing staff are encouraged to be advocates and ensure patients understood what appointments or tests they may need.
- Outpatient surveys were completed using a tablet computer. The results were collated and displayed for staff. We were told that, as a result of feedback from patients, that staff told patients about current waiting times as well as displaying them electronically.
- There was a wealth of leaflets for each specialty, along with many national specialist and support service leaflets from the relevant bodies. Leaflet trolleys were moved into place for each clinic so that the information available matched the clinic.
- Staff had training in caring for people with dementia. Department staff had added toilet door signs in red (the nationally recommended colour) for dementia patients as a direct consequence of learning from this training. The Butterfly Scheme was in place across the Trust however senior nursing staff working in the OPD were unable to clearly articulate what this meant in terms of patient care. The Butterfly Scheme provides a system of hospital care for people living with dementia or who simply find that their memory isn't as reliable as it used to be.
- Special procedures were in place when patients from a nearby high-security psychiatric hospital attended with high levels of supervision by guards for the protection of that patient and the general public. We were told that these patients were usually seen early in the morning when the department was empty of the public to protect the patients dignity and minimise contact opportunities with vulnerable people.
- Where patients attend who have learning disabilities or who exhibit disruptive behaviour arrangements were made for them to be seen quickly to reduce their time in the department. A quiet area for waiting was found, if necessary. There were two link nurses working in the OPD but they told us they rarely saw people with hospital passports as often these people went directly to wards. We spoke with one senior nurse in OPD1 who was very unclear about the Trust strategy on providing support for people with learning difficulties or cognitive impairment. Information was available for staff but this was not being used in practice. In other area of the OPD, such as in ophthalmology, support for people with particular needs was very good.
- The Trust used a phone translation service, holding three way telephone conservations so that both parties could hear the translator. The Trust had recently trained 18 Nepalese staff to interpret in conjunction with Southampton University. The need had been identified through engagement with the local community and as a result of a realisation that the community size would increase as a result of legislative changes that enabled Nepalese Ghurkhas to remain in the UK.
- Bariatric equipment such as seating, wheelchairs, hoists and couches were available in each outpatient area.
- The ocular services worked with the voluntary sector to ensure that the needs of visually impaired people were addressed. An Eye Clinic Liaison Office was employed through voluntary funding. The unit had been designed in consultation with local user groups representing visually impaired people. The Trust had been presented with the Clinic Service of the Year Award by the Macular Society for the second year running.
- An extract from the patient survey dated July 2014 showed that of the people recording that they had a disability; two thirds felt that the treatment and consulting rooms were very accessible but a third of respondents said they had great difficulty accessing the facilities.

Learning from complaints and concerns

- The total number of complaints relating to the OPD had reduced by 28% over the preceding year. The number of formal complaints in this period had reduced by 14% despite OPD patient numbers increasing year on year from 2006/7 2 when there were approximately 180,000 OPD attendances to 2013/14 when there were just over 250,000 attendances.
- The OPD was located close to the Patient Advice and Liaison Service (PALS) office; we were told that the OPD sisters and matron worked closely with the PALS team to resolve situations locally, at point of contact. It was felt this contributed to the reduction in formal complaints.
- Complaints were discussed at departmental level and also at Directorate Clinical Governance Group meetings. Learning from complaints was fed back to staff during the monthly departmental meetings; we saw minutes that corroborated this.

Are outpatients services well-led?

Outpatients

Good

Overall, the service was well led. Staff felt their line managers were approachable, supportive and open to receiving ideas or concerns. We found that there was some uncertainty about the detail of department management by one of the senior nurse but this may have reflected that they were 'acting up' following the recent death of their own line manager.

Staff knew and understood the vision; they could demonstrate how this was implemented in practice. Staff told us they enjoyed their work and felt that it made a difference to how patients felt about the hospital.

The development of the Mobile macular Unit was a particularly good example of service development in response to an identified need for service improvement. The ophthalmology service has developed a link with Zambia for ophthalmology, which has developed improved techniques aspects of care throughout Zambia.

Vision and strategy for this service

- The OPD steering group had a strategy that was updated and reviewed every 18 months that provided direction, and reflected the changing NHS. It had developed set standards of expectations such as clinic length (face to face time per session). A trust dashboard for outpatients was available aid managers and clinicians in making improvements to the service.
- Staff who we spoke with were able to tell us the vision for the OPD which was, "To provide excellent local outpatient services which are highly efficient, valued and trusted by both patients and GPs, delivered by a positive forward thinking workforce".
- The Review of Strategy and Objectives (July 2014) – Outpatients confirmed the vision was as the staff had told us and that this would be delivered through five workstreams looking at effectiveness, appointments, patient experience and quality of care, use of technology and informatics and marketing and site strategy. The document set out clear objectives with timescales for service improvements. There was evidence (in the form of RAG rating) of monitoring the implementation of the strategy.
- The Head of Nursing talked to us about the use of technology to improve the patient experience in the OPD. They talked to us about the current touchscreen technology to allow people to check in for their appointments. There was development work in progress at the time of the inspection that would see this develop further to allow individual patient journeys to be tracked as they moved through the department. Nurses were currently logging this information (such as the time a patient was seen by a doctor) manually; increased use of technology would release nursing staff to provide more direct patient care. The information gathered using this technology was to be used to make changes to the clinic timings and capacity.

Governance, risk management and quality measurement

- An annual clinical governance report for the OPD was produced and presented to the Trust Clinical Governance Committee.
- In governance terms, the OPD was part of the medical directorate whilst outpatient booking and medical records were managed centrally. There was an outpatient steering group, chaired by a consultant, which met monthly to oversee the implementation of the outpatient strategy with an operational group that covered more day-to-day issues.
- The outpatient services were overseen by the Outpatient Steering Group which had executive membership as well as senior managers and clinicians. The steering group linked to the Hospital Executive Board and Trust Quality Group. Outpatient service performance was discussed as the weekly Trust Performance meeting. We saw that the Outpatient Steering Group was effective; one example given was that with an ongoing heightened awareness, the 'Did Not Attend' (DNA) rates improved to 5.7% in March 2014. The Outpatient Steering Group was reviewing the DNA policy and process with the aim of reducing the rates further.
- The outpatient operational group met with the key Head of Departments to review and agree in more detail how the strategy was implemented and formed the membership for some of the working groups. The outpatient operational group was attended by managers from across the outpatient pathway: the matrons from ophthalmology, gynaecology and the main OPD, the sister from paediatric outpatients, a representative from radiology and pathology, the Head of Nursing for outpatients and a representative from

appointments. The group members brought information, concerns and ideas from their area to this group and then took information back to their staff. The group was supported by a transformation project manager. We were given the example of two members of the outpatient operational group reviewing the quality board in the inpatient areas and adapting these to reflect the right quality items for outpatient areas as evidence of the effectiveness of this group.

- We saw Local Risk Registers for directorates that included the OPD which enabled the Corporate Governance Group to understand the most significant risks and approve action to mitigate those risks. Gynaecology Risk Register 2014/15 which demonstrated an integrated approach to risk management across the directorate.
- The outpatient matron and Haematology Day Unit lead nurse or sisters attended the Trust Clinical Risk Group, as well as other Trust groups such as those for decontamination, nursing clinical practice, transport and matrons/ sisters meetings. This demonstrated a commitment to the sharing of information and dissemination of learning.

Leadership of service

- The Chief Executive Office sent regular emails to staff and invited all staff to attend his monthly briefing session. Staff told us that they found this helpful and that they were encouraged to attend briefings and cascade information to colleagues. Heads of Departments were encouraged to use the briefing notes to inform other staff.
- The staff who we spoke with told us that the Director of Nursing (occasionally referred to as Chief Nurse) was always helpful and supportive as was the Head of Nursing for outpatient services. Staff said that they could approach their line manager and senior managers with any concerns or ideas. These conversations helped us to judge that the organisational leadership had created an open and collaborative approach across the Trust.
- The Head of Nursing for outpatients, the main OPD matron, and the appointments manager met on a six to eight weekly basis with the matron/sister from the Fleet and Farnham sites to ensure consistency and continuity of services for the Trust, as the premises and nursing staff were not managed by them. Practical examples that we were given of outcomes from these meetings included; sending a paediatric nurse to the Farnham site to provide cover for safeguarding as Farnham did not have any paediatric trained staff. The meetings were also a useful means of reinforcing the Trust procedures for decontamination, discussing booking processes and reviewing as patient feedback using the questionnaires.

Culture within the service

- We were told by staff that they were asked for their ideas and that the Head of Departments welcomed their thoughts on how to improve practice. We were given the example of where it was agreed to hold the staff briefing and handover in OPD 1 at 8.00am as the staff now started at this time. This improved the department communication and planning for the day as staff from this area were then disseminated to four clinic locations across the hospital.

Innovation, improvement and sustainability

- We were told by staff that their managers welcomed ideas for service improvement. Where nurses raised concerns about equipment, they were encouraged to put forward suggestions for better, alternative equipment and, where appropriate, this was then formally requested. A recent example involved having individual forceps packs in ENT clinics.
- The Macular service provided a good example of a Trust service improvement process. The macular service was identified as a particular area needing improvement due to clinical and patient feedback and increased capacity issues. A stakeholder group was set up to brainstorm ideas and staff looked at the services provided by other Trusts. A demand and capacity analysis was undertaken to identify the extent of current and projected capacity issues. A risk and cost analysis of the improvement ideas and an options appraisal was undertaken. This led to a business case for a mobile unit being presented to the Hospital Executive Board for final agreement. The Trust ensured sound measuring of the current situation to ensure the level of change required was understood and created measures of success. These targets included increased patient satisfaction over time, more weekly clinic slots on the mobile unit and maintaining follow up times continued to be met. A service design plan was drawn up which included staff hiring and training, vehicle building and IT systems being set up. The programme was then piloted and implemented; there was an 'away day' with the clinical team to design the mobile unit with a simulated clinic

walkthrough to prevent patient bottlenecks. At the time of the inspection visit the mobile macular service was fully operational. Outcome measures were being decided and the service was being audited against these to create a performance baseline: Feedback from patients was very positive with reduced waiting times, a service closer to home and better parking facilities.

- The ophthalmology service has developed a link with Zambia for ophthalmology, which has developed improved techniques aspects of care throughout Zambia.

Outstanding practice and areas for improvement

Outstanding practice

- The A&E department had been redesigned by taking patients' views into account, and provided an environment that helped to deliver exceptional patient care (including specific dementia-friendly areas).
- The four-hour target was consistently met, and the other core services that worked with the A&E department acknowledged that the target was everyone's responsibility.
- Joint working between the elderly care physicians and the A&E department led to improved patient experience and reduced unnecessary admissions.
- 'Round table' discussions were used as a learning tool, and there were well-developed Mortality and Morbidity (M&M) meetings, which included dissemination to all levels of staff.
- There was a drive to increase incident reporting by all staff groups, especially medical staff (i.e. doctors).
- The management of medical outliers, including the method of communicating with teams, ensured ownership and daily (early) review.
- Specialist advice was available for GPs and the A&E department and rapid access clinics reduced unnecessary admissions.
- Theatre utilisation had improved, and resulted in a cancellation rate of 0.6% between October 2013 and June 2014.
- There were communal dining areas on the orthopaedic wards.
- There was a high standard of care provided for patients at the end of their life, and we saw that staff went to great lengths to respect and accommodate the wishes of patients and their families, including the use of the 'Time Garden'.
- The trust used and audited the trust wide 'Personalised Care Plans for the Dying Patient' in place of the previously used Liverpool Care Pathway.
- The A&E department used memorial boxes for recently bereaved relatives and contacted them six weeks following the death of a relative.
- The ophthalmology service had received a 'Clinical Service of the Year' award from the Macular Society
- Joint working with specialist providers allowed patients to attend outpatient clinics closer to their home rather than having to travel to another provider further away.

Areas for improvement

Action the hospital SHOULD take to improve

- Review nursing staffing levels and skill mix in Paediatrics (services for children).
- Ensure paediatric staff have the necessary skills to identify and manage the deteriorating child.
- Review how training data is recorded within paediatrics to ensure that records are accurate.