Care Quality Commission

Royal Berkshire NHS Foundation Trust

Royal Berkshire Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	Good
Medical care	Requires improvement
Surgery	Requires improvement
Intensive/critical care	Requires improvement
Maternity and family planning	Requires improvement
Services for children & young people	Good
End of life care	Good
Outpatients	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

Royal Berkshire Hospital is the main acute hospital for the Royal Berkshire NHS Foundation Trust, which provides acute medical and surgical services to a population of 600,000 people across Reading, Wokingham and West Berkshire, and specialist services to a wider population across Berkshire and the surrounding borders. The Royal Berkshire Hospital is the only site that provides inpatient provision overnight. The trust also has five other sites including West Berkshire Community Hospital, Windsor Dialysis Unit, Prince Charles Eye Unit, Royal Berkshire Bracknall Clinic and Townlands Hospital Outpatients.

During the inspection, in addition to the Royal Berkshire Hospital site, we visited West Berkshire Community Hospital (Day Surgery Unit and Outpatient services), Windsor Dialysis Satellite Unit and Prince Charles Eye Unit.

We carried out this comprehensive inspection because the Royal Berkshire Hospital NHS Foundation Trust was initially placed in a high risk band 1 in CQC's Intelligent Monitoring system. However, when the latest Intelligent Monitoring bandings were updated the trust was placed in a low risk band 5. The inspection took place between 24 and 26 March 2014 and an unannounced inspection visit took place on 29 March and 2 April 2014.

Overall, this hospital requires improvement. We rated it 'good' for being caring and effective, but it requires improvement in providing safe care, being responsive to patients' needs and being well-led.

We rated A&E, end of life care and services for children and young people as good, but we rated outpatients, medical, surgical, maternity and critical care as requiring improvement. Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The hospital was clean and well maintained, although there were some examples where cleanliness fell below expected standards.
- The workforce were committed and we noted an open culture during the inspection.
- Infection control rates in the hospital were similar to those of other trusts except the C.Difficile rates, which were higher than average and the trust was taking steps to make improvements.
- Staffing levels were not always sufficient to meet the needs of patients on all ward areas, with a consequent reliance on bank and agency staff.
- Medical records and the electronic patient record system and processes were not robust, which resulted in patient records not being available, reliance on temporary records and inability to access records as required in a timely manner, which impacted on the ability to deliver care.
- Critical care capacity was insufficient and operations were going ahead when there had been a potential need for critical care post-surgery identified and no critical care bed was available.
- The observation ward in A&E was a room with three beds but it was not included in the four-hour decision to discharge, admit or treat A&E target as it was used as a ward, although it did not have any shower facilities. There were concerns about appropriate use and care of patients in this observation area.
- The major incident process associated with decontamination was not appropriate because of the distance and journey for patients through the hospital.
- Safeguarding processes and knowledge of the Mental Capacity Act was not sufficient.
- DNACPR forms were not consistently completed.
- The end of life care team worked collaboratively with key stakeholders.
- Paediatric care was generally positive.

We saw several areas of outstanding practice including:

- Caring interventions and support for families in the Intensive Care Unit.
- The Children's A&E department.
- Consultant geriatricians worked in the A&E department 8am to 8pm seven days a week.
- The responsiveness of the Palliative Care team.

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

Importantly, the trust must:

Summary of findings

- Ensure that medical records are kept securely, and records can be located and accessed promptly when needed to appropriately inform the care and treatment of patients.
- Maintain the privacy and dignity of patients placed in the observation bay in the A&E department.
- Ensure that the design and layout of the emergency department protects patients and staff against the risks associated with unsafe or unsuitable premises.
- Take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed to care for patients' needs, and safeguard their health, safety and welfare.
- Accurately complete 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and document the discussions about end of life care with patients.
- Take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe by planning the delivery of care and appropriate treatment meet the patients' individual needs and have procedures in place to deal with emergencies which are reasonably expected to arise.
- Review the ICU capacity across the trust; employ suitably qualified, skilled and experienced staff; and have necessary equipment available to care for patients who require intensive or high dependency care.
- Ensure that planning and delivery of care meets patients' individual needs, and ensure the safety and welfare of all patients.
- Increase staff knowledge of Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding.
- Improve contemporaneous record keeping by all staff to avoid misplacing records of care and observations.
- Ensure the staffing levels and admission criteria in the Rushey Midwife-led unit is maintained to ensure safe care is provided to all women.
- Ensure that at all times there is a sufficient number of suitably qualified, skilled and experienced staff employed to provide safe midwifery care in all areas.
- Take action to improve the ventilation system on the delivery suite, to protect patients and others who may be at risk from the use of unsafe equipment.

In addition the trust should:

- Ensure patient flow and discharge enables patients in the A&E to be admitted to wards without undue delay.
- Ensure patients are supported with access to information in a language that meets their needs throughout the hospital.
- Ensure that staff are appropriately trained to care for patients with dementia.
- Improve the visibility of the executive team throughout the hospital and be open with the workforce regarding the strategic direction for the trust.
- Ensure that all equipment is properly checked, maintained and documented with sufficient equipment available to meet needs of all patients.
- Utilise the Intensive National Audit and Research Centre Case Mix programme (ICNARC data) to drive improvements and meet standards of care.
- Ensure a regular programme for changing disposable curtains.
- Ensure that appropriate risk assessments are undertaken where patients remain in the A&E department for a prolonged period.
- Ensure that shift lead handovers in A&E take place without interruptions to ensure prompt communication.
- Ensure that access to CAMHS services are timely and meet the needs of patients.
- Ensure that access to equipment for use in chemical biological or hazardous incidents is easily accessible.
- Ensure all staff are aware of the process to raise concerns in accordance with trust policy.
- Ensure that communication to GPs following a consultation or inpatient stay is consistently documented and sent in a timely way.
- Review transition processes for young people with all long term chronic conditions.

There were also areas of practice where the trust should take action which are identified in the report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Overall we rated the safety of services in the trust as 'requires improvement'.

Nursing staffing levels were insufficient on many wards and consequently there was a significant reliance on agency and bank staff. The agency and bank staff were appropriately checked and had an induction checklist carried out. The trust was taking steps to recruit nurses internationally due to the difficulty in recruiting. Midwifery staffing was a concern in the Rushey unit, however, immediately after our inspection the trust closed two beds until further staff were recruited. Consultant presence in obstetrics was not in line with national standards. Medical staffing out of hours was a concern, particularly in medicine. Due to capacity pressures and workload, medical staffing needed improvement in some areas and in particular the critical care unit as consultants regularly needed to stay in overnight when they were on call.

Clinical data was not always easily accessible due to the fragmented structure of the trust's electronic patient record (EPR) and patient records were not easily accessible or well-maintained with an over-reliance on 'temporary' records. This affected patient care as significant information was not available and in some instances patients had more than one test as the initial result was not available. The trust recognised the safety concerns relating to medical records and set up a working group led by the interim medical director to address the issues as a priority.

Medical equipment checks were not consistently completed or recorded and staff reported difficulties in being able to get equipment checked or replaced.

Are services effective?

Good

Overall we rated the effectiveness of the services in the trust as 'good'.

Most patients were treated according to national evidence-based guidelines and clinical audit was used to improve practice. There were good outcomes for patients and mortality rates were within the expected range. Seven-day services were in development and there were good examples of seven-day working. There were good examples of robust ward rounds and multi-disciplinary team working with input from allied health professionals. There were examples of clear documented pathways of care.

Summary of findings

Are services caring?

Good

Overall we rated the caring aspects of services in the trust as 'good'.

Overall, patients received compassionate care and were treated with dignity and respect. The Critical Care service provided some excellent caring interventions both for the patients and their families, with positive feedback about their bereavement service. Patients and relatives we spoke with said they felt involved in their care. There were examples of patients not feeling appropriately cared for in A&E and some ward areas where staff were busy. Staff acknowledged that, at times, workload pressures could prevent the level of care and support patients needed. Staff were extremely committed and aimed to put the needs welfare of patients as their priority.

Are services responsive to people's needs?

Requires improvement

Overall we rated the responsiveness of services in the trust as 'requires improvement'.

The trust faced significant capacity pressures. The A&E department was not consistently meeting the four-hour target for treatment, admission or discharge. The department was designed for 65,000 attendances but had around 100,000 attendances a year at the time of the inspection. This resulted in patients waiting in corridors to be seen and, in some instances, spending longer than 12 hours in A&E.

The flow throughout the trust was not robustly managed, with patients who were clinically fit for discharge not being discharged in a timely manner. There were significant waiting times for radiology diagnostic procedures, which impacted on both inpatients and outpatients. The trust was taking steps to improve the radiology waiting times and looking at other ways of providing diagnostic treatment.

The critical care capacity was not sufficiently meeting the demand and resulted in either patients' operations being cancelled or patients staying in recovery overnight. The trust did not have clear robust plans to address the capacity and flow issues. However the appointment of the interim chief operating officer was intended to concentrate on addressing them.

Are services well-led?

Requires improvement

The trust's leadership was rated as 'requires improvement'. Many of the executive team were interim positions and the former chief executive had left in December 2013. The trust had proactively commissioned a review into its leadership and governance processes and we had confidence that they were beginning to take appropriate steps to address some of the trust wide issues found during the inspection. They were aware of the potential risks associated with interim posts and were in the process of appointing

a new chief executive. This recent instability in leadership has resulted in front line staff not feeling fully informed about the recent changes and unclear on the overall vision for the trust. Staff did not feel the executive team were visible enough, although many staff told us that the Director of Nursing was more visible and had 'made a difference' in the relatively short time she had been in post since June 2012.

Whilst the trust board was aware of the improvements that were required, they were facing a legacy of some areas of governance not being standardised or robust and systems and process being inconsistently applied, which would take some time to address. During the inspection there was some evidence of improvement starting, but it was too soon to establish the impact. There were some areas that needed stronger leadership from the board to the ward to realise the required changes.

Summary of findings

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

Accident and emergency

Good

The A&E department was significantly challenged with capacity issues, which directly impacted on its ability to meet the four-hour target for treatment or discharge. This was mainly due to lack of beds available on a ward, delay in A&E and specialty review, or delay in transport. Some patients were staying in the A&E department for over 12 hours.

The department had a process of 'STATing' for immediate review of patients arriving by ambulance to assess whether the patient required immediate review and treatment, or could wait in a queue. Patients were observed waiting on trolleys and chairs in the corridor for over two hours waiting to be seen.

An 'observation ward', which had space for three beds, with a toilet but no shower, was seen accommodating four patients, which impacted on their privacy and dignity. This area was not subject to the A&E four-hour target. Access to support for mental health patients was variable.

In response to the capacity issues, the team had done work to review the exiting pathways and flow within the department. However, an inconsistent trust-wide systematic approach to discharging patients, to make beds available, was not robust.

Overall A&E was clean. Staff were caring and attentive to patients' needs, treating them with respect, although there was mixed feedback from patients prior to our inspection. Leaders in the A&E department were open and approachable. The inspection team noted the Children's A&E to be of a particularly high standard.

Medical care (including older people's care)

Requires improvement

Overall the cleanliness and hygiene on the wards was adequate, although some areas fell below expected standards. Nurse staffing levels were at times insufficient with a reliance on bank and agency staff. This was particularly on wards for older people, including wards where elderly patients were not always placed on the most appropriate ward for their needs, due to capacity pressures. Whilst training was available in dementia care, many staff had not attended and some were unaware of the availablity of training.

We were told that a shortage of medical cover out of hours and during weekends, delayed care and discharges. The hospital did have a hospital at night team to improve care out of hours. Patients

Summary of findings

were kept on medical wards long after they were assessed as being medically fit for discharge. There were notable lapses in medicines management, with insufficient understanding of drug storage requirements.

Clinical data was not always easily accessible due to the fragmented structure of the trust's electronic patient record (EPR) and patient records were not well maintained with an over-reliance on 'temporary' records. There were standardised care pathways and care plans, but these were not consistently used.

Medical wards were compassionate and caring, with good leadership on the majority of wards.

Surgery

Requires improvement

Nurse staffing levels were insufficient due to vacancies with a consequent reliance on bank and agency staff. Checking and maintenance of equipment was inconsistent across the service. Capacity pressures across the trust resulted in patients' operations being cancelled or delays in patients being admitted to a ward post-operatively, with some patients being cared for in the recovery area overnight.

The 18 weeks from referral to treatment (RTT) targets were not consistently being met. A variation in practice for pre-operative assessments led to operating lists being changed on the day, or patients' treatments being cancelled. Completion of the WHO surgical checklist was consistently embedded in practice.

Patients were treated with respect, dignity and compassion. Whilst there was positive feedback about managers and matrons, there was a reliance on goodwill and staff felt there was no cohesion over the directorate, as areas worked independently without a clear vision or robust forward planning.

Intensive/critical care

Requires improvement

Medical staffing levels were not sufficient to meet the needs of ICU and HDU, particularly when HDU had ventilated patients due to capacity pressures in ICU. These pressures also resulted in patients being cared for in the recovery area.

The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme, and outcomes were within expectations for the size of the unit. Staffing pressures prevented proactive review of performance data.

Summary of findings

Feedback from patients and relatives was overwhelmingly positive with excellent caring interventions and patients and families always being involved and informed of care. The bereavement service was well established and there were twice yearly memorial services in memory of patients.

Maternity and family planning

Requires improvement

Midwifery staffing levels were found to be insufficient to provide a consistently safe service, especially on Rushey ward. However, following our announced inspection, the trust closed two beds to manage capacity and associated safety risks. Medical staffing did not meet the recommended national guidelines for consultant presence on the unit. The ventilation system within the delivery suite had been identified as not meeting standards expected, which meant that staff were potentially at risk from inhaling excess nitrous oxide. Essential maintenance of equipment would often take some time. Baths on Rushey ward were used for labour and delivery, and evacuation equipment in the event of a sudden maternal collapse was not available in these rooms. However, the trust closed these rooms following the announced inspection, until a formal review could be carried out regarding their safety.

Instrumental and caesarean section rates were higher than expected. Inductions of labour were subject to delay due to workload pressures. The maternity service had a policy to divert women to neighbouring trusts due to lack of capacity or high workload, which was implemented at least once a month. At these times the home birth service could also be suspended.

Care was delivered with kindness and compassion. Patients and their partners were involved, and emotional support was good, particularly in times of bereavement. There was a visible and supportive midwifery and obstetric management team and there was an open and honest culture with a well-defined governance structure.

Services for children & young people

Good

Babies, children and young people were cared for in wards and departments that were clean. Infection control practices were adhered to. There were sufficient nursing and medical staff across all areas. Staff used recognised early warning systems for both neonates and paediatric patients. Staff reported incidents, and learning was shared across the area to prevent the likelihood of a reoccurrence. Security for patients and staff in the neonatal and paediatric areas was good. Access to mandatory and additional training was available to staff, to allow them to develop additional skills.

Summary of findings

Care and treatment was delivered in line with national guidelines. Outcomes were reviewed, and there was active participation in research and audit. Care plans and pathways were in use. Multidisciplinary team working was good in all areas.

Staff provided care in a kind and compassionate manner. Parents were involved in both decision-making and the delivery of care and were given appropriate emotional support. There was a highly visible leadership team and an open and supportive culture.

End of life care

Good

The palliative care team was available seven days a week, with the hospice providing out-of-hours cover. Medicines were provided in line with guidelines for end of life care. DNACPR forms were not consistently completed in accordance with policy and there were no standardised processes for completing mental capacity assessments.

Training relating to end of life care was provided at induction and study days were arranged for palliative care link nurses from wards. Leadership of the palliative care team was good and quality and patient experience was seen as a priority.

All patients requiring end of life care could access the palliative care team. Viewing times in the mortuary were limited, which impacted on patients' families being able to view their relative. There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their preferred place of care.

Relatives of patients receiving end of life care were provided with meal vouchers and free car parking. Patients were cared for with dignity and respect and received compassionate care. The 'End of Life Care Plan' was the pathway patients were placed on in the last few days of life.

Outpatients

Requires improvement

Patients received kind and compassionate care and were treated with dignity and repsect, and their privacy maintained. Patients told us that staff were kind and they felt involved in their care. One-stop clinics and specialist clinics were provided.

Medical records were not consistently available at all clinics for each patient because of 'missing' notes. Shortages of staff in clinics and administration resulted in long waiting times for patients. In addition, delays in radiology significantly affected the efficiency of the outpatient service. There was a singificant variation in the time between an outpatient consultation and the GP receiving the outcome letter of within one week to six weeks.

Summary of findings

There was also a lack of information in any alternative language or format other than in English. The outpatient department staff felt supported and learning was communicated from incidents and complaints.

Summary of findings

What people who use the hospital say

- We held a listening event, which 128 people attended. Some people told us about us that they had good care at Royal Berkshire Hospital. However, people had concerns about the long waiting times in A&E particularly for care of older people.
- The Adult Inpatient Survey in 2012 Royal Berkshire Hospital NHS Foundation Trust scored 'about the same' as other trusts for all 10 areas. The trusts performance had reduced in one area and improved in three areas. Of the 60 questions asked the trust performed better than other trust in one question.
- The results from the Friends and Family Test (FFT) between September 2013 to December 2013 show the trust has scored below the England average for all four of the months, achieving the lowest in October. Response rates were fairly consistent over the four months. The performance since January 2014 has improved on a consistent trajectory. A&E scores compared to the England averages were higher in two months and lower in two months.
- The Cancer Patient Experience Survey (CPES), Department of Health, 2012/13, showed that out of 69 questions, for which the trust had a sufficient number of survey respondents on which to base findings, the trust was rated by patients as being in the bottom 20% of all trusts nationally for 14 of the 69 questions and performed better in 9 questions.
- CQC's Survey of Women's Experiences of Birth 2013 showed that under the 'Care during labour and birth' that the trust is performing better than other trust's for one of the three areas of questioning. Comparison with the 2010 results highlighted an upward trend in one of the eight questions. The other seven questions saw no change in the results.
- Between January 2013 and February 2014, Royal Berkshire Hospital had 294 reviews from patients on the NHS Choices website. It scored 4 out of 5 stars overall, with 91 comments with a rating of 5 stars and 34 with a rating of one star. The highest ratings were for cleanliness, staff co-operation, dignity and respect, involvement in decisions and same sex accommodation. The lowest ratings were for staff being rude, breach of confidentiality, patient aftercare, pain management and communication.
- Patient-Led Assessment of the Care Environment (PLACE) is self-assessments undertaken by teams focus NHS and independent healthcare staff and also the public and patients. In 2013, Royal Berkshire scored greater than 92% for all four measures, with cleanliness scoring the highest at 99%.
- During our inspection, patients told us that staff were kind, caring and compassionate.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Ensure that medical records are kept securely and records can be located and accessed promptly when needed to appropriately inform the care and treatment of patients.
- Maintain the privacy and dignity of patients placed in the observation bay in the A&E department.
- Ensure that the design and layout of the emergency department protects patients and staff against the risks associated with unsafe or unsuitable premises.
- Take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed to care for patients' needs, and safeguard their health, safety and welfare.
- Accurately complete 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, and document the discussions about end of life care with patients.
- Take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe by planning

Summary of findings

the delivery of care and appropriate treatment to meet patients' individual needs, and have procedures in place to deal with emergencies which are reasonably expected to arise.

- Review the ICU capacity across the trust; employ suitably qualified, skilled and experienced staff; and have necessary equipment available to care for patients who require intensive or high dependency care.
- Ensure that planning and delivery of care meets patients' individual needs, and ensure the safety and welfare of all patients.
- Increase staff knowledge of Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding.
- Improve contemporaneous record keeping by all staff to avoid misplacing records of care and observations.
- Ensure the staffing levels and admission criteria in the Rushey Midwife-led unit is maintained to ensure safe care is provided to all women.
- Ensure that at all times there is a sufficient number of suitably qualified, skilled and experienced staff employed to provide safe midwifery care in all areas.
- Take action to improve the ventilation system on the delivery suite, to protect patients and others who may be at risk from the use of unsafe equipment.

Good practice

Our inspection team highlighted the following areas of good practice:

- Caring interventions and support for families within in the Intensive Care Unit.
- The Children's A&E department.
- Consultant geriatricians worked in the A&E department 8am to 8pm seven days a week.
- The responsiveness of the Palliative Care team.

Royal Berkshire Hospital

Detailed findings

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

Our inspection team

Our inspection team was led by:

Chair: Professor Kay Riley, Chief Nurse, Barts Health

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of 45 included CQC inspectors and analysts, consultants, junior doctors, senior nurses, a student nurse, a senior physiotherapist, patients and public representatives, Experts by Experience and senior NHS managers. Some team members were present at the inspection for one of the two days on site.

The Patients Association was also part of our team to review how the trust handled complaints.

Background to Royal Berkshire Hospital

The Royal Berkshire Hospital is the main site of the Royal Berkshire NHS Foundation Trust, which provides acute medical and surgical services to a population of 600,000 people across Reading, Wokingham and West Berks, and specialist services to a wider population across Berkshire and the surrounding borders. The trust also has five other sites that the Royal Berkshire Hospital links with: West Berkshire Community Hospital, Windsor Dialysis Unit, Prince Charles Eye Unit, Royal Berkshire Bracknall Clinic and Townlands Hospital Outpatients. The Royal Berkshire Hospital employs around 5,000 staff and has 745 beds and 22 operating theatres (across three surgical sites).

During the inspection, in addition to the Royal Berkshire Hospital site, we visited West Berkshire Community Hospital (Day Surgery Unit and Outpatient services), Windsor Dialysis Satelite Unit and Prince Charles Eye Unit.

The Royal Berkshire NHS Foundation Trust gained foundation trust status in June 2006. The trust had recently been under enforcement action from Monitor due to its A&E consistently failing to meet the four hour target, its financial stability, quality governance and C. difficile rates. However, at the time of the inspection these concerns had been signed off by Monitor and the trust was rated as green, with no evident governance concerns and a financial stability rating of two, meaning that there was a material level of financial risk.

We inspected the Royal Berkshire NHS Foundation Trust as part of our in-depth hospital inspection programme. We chose the trust as it was placed in Band 1 of our new intelligent monitoring model and considered to be a high risk service. The model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. The intelligent monitoring model is reviewed quarterly and the trust was placed in Band 5 when reviewed, which significantly reduced the risk banding immediately prior to the inspection.

Detailed findings

At the time of the inspection, the executive team was going through a period of change. The former CEO had left in December 2013 and the former medical director was acting as interim CEO. The trust considered itself a clinically-led organisation, with five board members from a clinical background. The trust did not have a chief operating officer, but had immediate plans for an interim to commence in post. The executive team comprised of a significant number of interim appointments, which presented challenges for consistent leadership.

Facts and data about the Royal Berkshire Hospital

Context

- Foundation trust since June 2006
- Approximately 745 beds
- Population 600,000
- Staff approximately 5,000
- Annual turnover: 330 million
- Deficit: £2.68m in 2012/13

Activity (2012/13)

- Inpatient admissions 94,755
- Outpatient attendances 449,627
- A+E attendances 101,497

Intelligent Monitoring – Low risk (March 2014)

- Safe: Items = 8, Risks = 1, Elevated = 0, Score = 1
- Effective: Items = 31, Risks = 0, Elevated = 1, Score = 2
- Caring: Items = 18, Risks = 0, Elevated = 0, Score = 0
- Responsive: Items = 10, Risks = 0, Elevated = 0, Score = 0
- Well led: Items = 26, Risks = 2, Elevated = 0, Score = 2

Total: Items = 93, Risks = 3, Elevated = 1, Score = 5

Safety

- 4 never events (Dec 2012 - Jan 2014)
- STEIs 93 SI's (Dec 2012 - Jan 2014)
- NRLS: Deaths 13, Severe 5, Abuse 14, Moderate 680

Caring

- CQC inpatient survey (10 areas): Average for all 10 areas
- Cancer patient experience survey (69 questions): Above for 9 questions, Average for 46 questions, Below for 14 questions

Responsive

- Bed occupancy: 89.1%
- A&E: four hour standard: Below average
- Cancelled operations: Similar to expected
- Delayed discharges: Similar to expected
- 18 week Referral to treatment (RTT): Similar to expected
- Diagnostic target: Below average

Well-led

- Staff survey (28 questions): Above average for 18 questions, Average for 6 questions, Below for 4 questions
- Sickness rate 3.5 %: Below national average

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 Royal Berkshire 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.

In addition, the inspection team also inspected the following core services at other locations linked to the Royal Berkshire Hospital:

- Medical provision at the Windsor Dialysis Satellite Unit
- Day surgical and outpatient services at West Berkshire Community Hospital
- Surgical services at Prince Charles Eye Unit.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included

Detailed findings

the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event, in Reading on 24 March 2014, when 128 people shared their views and experiences of the Royal Berkshire Hospital. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 24 and 26 March 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We carried out unannounced inspections on 29 March and 02 April 2014. We looked at how the hospital was run out of hours and at night, the levels and type of staff available and the care provided.

Good

Accident and emergency

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

Information about the service

The Royal Berkshire hospital provides Accident and Emergency services through the main Accident and Emergency (A&E) Department, the Children's Accident and Emergency Department and the Emergency Care Unit (ECU). A&E is not a major trauma centre. Attendance at Accident and Emergency is in the region of 100,000 per year, which exceeds the 65,000 attendances that the department was built to accommodate.

The main A&E has 11 spaces for treating major cases, a four bay resuscitation area which is also equipped to treat children, a three trolley 'Senior triage assessment and treatment' (STATing) bay for initial assessment, a three bed observation ward, a triage room for minor cases and eight minor treatment bays. The department also has an ENT/Eye treatment room and an interview room.

The Emergency Care Unit provides care for patients under the care of A&E, where they can receive treatment or investigations, but can be discharged within 24 hours. The unit has provision for trolleys and chairs which can flex dependant on the needs of patients. Nurse-led clinics for ambulatory patients with conditions such as headache, cellulitis and deep vein thrombosis, are run daily from 8-6pm.

The Children's A&E has three spaces to treat major cases and four side rooms, one of which is a plaster room. Nursing staff are supported by play leaders during the day shifts. The paediatric short stay area is used for children to be cared for when they are seen in the Children's Accident and Emergency Department and require a period of observation before a decision to admit or discharge is made. This is open from 12 noon until midnight, seven days per week and is staffed from the Children's Accident and Emergency Department by one registered nurse (child) and one playleader.

Good

Accident and emergency

Summary of findings

The A&E department was significantly challenged with capacity issues, which directly impacted on their ability to be able to meet the four hour target for treatment or discharge. This was mainly due to lack of beds available on a ward, delay in A&E and specialty review, or delay in transport. Some patients were staying in the A&E department for over 12 hours.

The department had a process of 'STATing' for immediate review of patients arriving by ambulance to assess whether the patient required immediate review and treatment, or could wait in a queue. Patients were observed waiting on trolleys and chairs in the corridor for over two hours waiting to be seen.

An 'observation ward', which had space for three beds, with a toilet but no shower, was seen accommodating four patients; impacting on their privacy and dignity. This area was not subject to the A&E four hour target. Access to support for mental health patients was variable.

In response to the capacity issues, the team had done work to review the exiting pathways and flow within the department, however, an inconsistent trust-wide systematic approach to discharge of patients, to make beds available, was not robust.

Overall A&E was clean. Staff were caring and attentive to patient's needs, treating them with respect, although there was mixed feedback from patients prior to our inspection. Leaders in the A&E department were open and approachable. The Children's A&E was noted to be of particularly high standard by the inspection team.

Are accident and emergency services safe?

Good

There was a good mix of nursing and medical staff available across the 24 hour period. However, recruitment was ongoing, and use of bank and agency staff remained a regular occurrence. Bank staff were treated as part of the team and enabled to practice within their experience and skills. At busy times, when patients were queuing in the corridor, it was difficult to ensure that staff were allocated to their care.

The setting up and implementation of the STATing bay in A&E had improved the departments ability to immediately assess and treat patients on their arrival. However, at busy times this was not a seemless process and still resulted in patients experiencing delays in being seen.

Patients at risk of falling were identified, and a risk assessment undertaken with a red alert bracelet being used to indicate they were at risk of falling. Other potential risks, such as for patients living with dementia and pressure ulcers, were not routinely undertaken, although staff carried out a falls assessment for all patients living with dementia, and would transfer patients to a bed to reduce the risk of skin and pressure damage if they were to be admitted, but with a delay due to a bed not being available on a ward.

The environment in A&E was recognised as not being sufficiently large enough for the amount of patients attending A&E. This was of particular difficulty for patients with mental health issues.

Equipment was available and maintained, but some routine checking systems were not adhered to, which led to a lack of assurance that all equipment was in place and ready for use.

Cleanliness, Infection control and hygiene

- All areas of the main department we visited appeared clean, although dust was noted on a shelf of a bay on the Emergency Care Unit (ECU), and of six trolleys checked across all areas, two had some dust on the ledge under the mattress.

- The department had a range of equipment which was seen to be visibly clean, with a system of labels in place to indicate an item was clean and ready for use.
- We saw that staff used protective clothing appropriately, regularly washed their hands and used hand gel between dealing with patients.
- 'Bare below the elbow' policies were adhered to by all staff.
- The department had disposable curtains, some of which were noted to not be dated; others were dated as being changed in February 2014 and some in October 2013. We were told the housekeeping staff changed the curtains when they were dirty and that there was no programme for changing them at other times. We did not see any curtains that were visibly soiled, but a lack of dating when all were changed, and no routine programme for changing them, may pose a risk for cross infection.

Nursing Staffing

- Shifts in the main A&E were staffed with a mix of band 7 sister grade nurses, who would be in charge of the shift, with band six and band five nurses, healthcare assistants and student nurses completing the team. The department had been actively recruiting staff in the last year. In May 2013 there were 12 vacancies .This had reduced to two in March 2014.
- Figures for bank and agency staff usage for the past year showed around 400 shifts were covered in April 2013, dropping to 100 in September 2013 and to 200 in March 2014. These had mainly been filled by bank staff. Matron reported positive recruitment, and the use of bank and agency staff had reduced as recruitment had increased. However, there were still times when bank and agency staff were used, or department staff worked overtime to cover shifts. Bank staff on duty at the time of our visit felt part of the team, and were given good handovers for the areas they were allocated to work in.
- Nursing staff would be allocated to work in an area of the department or in the Emergency Care Unit (ECU) which was run as part of the department. Staff either worked a full shift in one area, or alternated depending on the length of their shift.
- In the Children's A&E, staffing was in line with national guidance with two trained staff, a healthcare assistant and a play leader on duty.
- When the department was busy, and patients were having to be placed in the corridor, either sitting on chairs or on trolleys, we did not see that there were sufficient staff allocated to observe these patients. While some were in view of the staff base, the staff working in the STATing bay and other areas were continually busy and being called away, and patients had to get their attention as they passed or relatives had to approach the desk.

Medical Staffing

- There were 13 whole time equivalent (wte) consultants in the unit, and consultants were present in the department from 8am to midnight. The shift pattern ensured overlap of consultants and access to senior staff, with a consultant who was also on-call. Overnight there was always a doctor of ST4 and above present, again with an overlap between shifts which allowed for handover to occur.
- Locums were employed at F2 and specialist registrar level to cover planned leave and sickness. Trust data showed that requests for doctor cover were made for long-term sickness, planned leave and unplanned sickness; however, the fill rate was lower than the number of requests, although we did not see evidence of short fall on rotas.
- Junior doctors told us there were adequate numbers of them in the unit out of hours, and that consultants were contactable by phone if they needed any support.
- The ECU was staffed by the doctors from Accident and Emergency with a consultant based on the unit. We saw that the team worked well together, with consultants being available for more junior doctors to discuss patients and provide advice.

Initial assessment of patients

- The department had a process of STATing for immediate review of patients on arrival in the department, for those that arrived by ambulance. There were guidelines in place for the flow of patients, and the process for STATing commenced on arrival in the department, either by ambulance or GP referral, where the allocated senior doctor took a handover from the ambulance staff. This enabled initial assessment and a decision on whether the patient should be placed in the 'STATing bay' for immediate medical and nursing review and treatment, or could be directed to wait in a queue to be reviewed.
- On arrival, patients were booked in and logged on the computer by the reception staff at the staff base. At this point a wristband should be applied. We observed that

two patients on trolleys did not have wristbands, which posed a risk for treatment and administration of medication when the department is busy and patients were waiting in the corridor queue.

- Walk-in patients were seen by a receptionist, and either referred directly to an Emergency Nurse Practitioner (ENP) in the minors area or to the triage nurse, where a decision would be made for the appropriate pathway, such as to STATing for further assessment, back to the waiting room, or a fast-track protocol for their initial diagnosis. Patients with chest pain were immediately assessed and transferred to the Resuscitation area. All notes we looked at demonstrated that these assessments were being completed appropriately, and pain relief and antibiotics were given promptly (within 30 minutes).
- Staff undertook risk assessment for those patients at risk of falls and for any patients living with dementia. Dependant on the score, the patients would have a red alert wristband, on which staff could write 'falls risk' in the box on the band so that it was visible to all staff, not just to those who were providing care to the patient. There was no routine assessment of patients for risk of pressure ulcers.

Management of the deteriorating patient

- The unit used a recognised national early warning tool, the NEWS score, to assess patients. Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- The resuscitation area was equipped with a paediatric bay, where specialist equipment was available to treat children by staff from the paediatric A&E.

Nursing and Medical Handover

- Nursing handovers occurred three times a day and consisted of information on patients presenting condition, any treatment given, tests undertaken or awaited, details of any recent hospital admissions, and any details of relevant social circumstances. Staffing for the shift was discussed, as well as any high risk patients or potential issues.
- A senior nurse would be in charge of the shift, and received an additional handover from the previous nurse in charge. We saw this handover was often difficult, as the nurse in charge from the previous shift was not able to be relieved from their responsibility in order to give the handover. The handover we observed took place in several small parts over a period of more than an hour, with both the current and new shift lead being called away several times by staff and patients. From speaking with staff this seemed to be a common occurrence. As a result, there was a risk that important information may be omitted from the handover.
- Medical handover occurred three times a day in the morning, late afternoon and night. Doctors were allocated to an area to work in during their shift at the handover.

Incidents

- All staff we spoke with stated that they were encouraged to report incidents and received direct feedback via their lead group mentor, the matron, department emails and teaching sessions.
- Staff were able to give examples of where practice had changed as a result of incident reporting.

Environment and Equipment

- The environment of the A&E department was not of a sufficient size to accommodate the number of patients attending. It was designed to accommodate 65,000 patients per year, but now sees over 100,000. We observed that at busy times patients had to queue in the corridor on chairs while waiting to be seen. For a period of two hours one evening we counted up to six patients on chairs and two on trolleys in the corridor. Space was further limited by the relatives attending with the patient. Staff reported that this was a common occurrence and that the numbers we witnessed were relatively low compared to other occasions. They advised that only one relative could stay with a patient while they waited in the corridor, as space was limited and accessibility impeded.
- The Children's A&E was able to provide treatment and assessment in three major bays and four side rooms. There was a separate reception and waiting area through which the treatment area was accessed. The environment was child-friendly, with murals on the walls, a play area and a further seated area within the department.
- The ECU had been set up after reconfiguration of the Acute Medical Unit (AMU) in October 2013. The unit had three bays accommodating 12 patients, which could change between trolleys or chairs depending on their need. An advanced nurse practitioner (ANP) ran two

clinics from ECU for ambulatory patients. Clinic rooms were of sufficient size. Staff told us that, as the waiting areas had been converted from offices, these were often not big enough to accommodate all waiting patients and relatives. We observed relatives waiting in the corridor.

- There were two side rooms available for patients who may pose a risk for cross infection.
- The radiology department was situated next door to the unit and was easily accessible and provided adult and children's X–rays. Staff were confident that access to computerised tomography (CT) or magnetic resonance imaging (MRI) scans was not delayed when required for urgent investigations at any time.
- Resuscitation trolleys were fully checked at each shift change in A&E, with records kept to corroborate this. Other equipment trolleys were checked, but there was a lack of records when problems were identified, with no documentation regarding resolution. Staff told us that they had recognised this as being a problem, and had identified 'area leads' or 'champions' to help overcome the deficit and tighten up on record keeping.
- On the ECU we found discrepancies in the checking of the resuscitation trolleys and other equipment. There was a daily sheet where checking tasks were allocated per shift. We saw gaps of several days in these checks. When we checked the actual log kept with the equipment these also had gaps. This was raised with the matron who confirmed that a book for checking the resuscitation trolley had been lost, and staff had started another one, but this had become confusing when the original book had been found.

Medicines

- Medicines in all areas were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked and were within range, but we saw there were some gaps in this recording in the main A&E.
- The department had access to a dedicated pharmacist who visited daily, Monday to Friday, to review medication. There was access to the on-call pharmacist out of hours, and to the emergency drug cupboard if required.
- On reviewing three patient's records where medication had been prescribed and administered, we saw that these had been prescribed clearly and given in line with the prescription. Patient's current medications were listed on the patient record as part of their assessment.
- Staff were observed carrying out the checks of the controlled drugs, which were undertaken daily. Staff told us this was being increased to occur at each shift.
- Staff were able to provide some medication for patients to take home if they were discharged from the department, including antibiotics and simple analgesia. We did not see any examples of discharge medication during our visit.
- The advanced nurse practitioners, emergency nurse practitioners and some nurses in the Children's A&E, had undertaken a prescribing course which enabled them to prescribe some medications independently.

Records

- The five patient records we reviewed contained details of patients presenting conditions, medical history and current medication. Information on their GP and next of kin were also recorded. These were included in the A&E notes and were in a folder to ensure all information was kept together.
- Once patients had been seen, either in the STATing bay or by ENP, observations of blood pressure and other vital signs were recorded, along with allergies and any blood taken for testing.
- All records were in paper format and all health care professionals documented information in the same place. Those we reviewed had been signed and dated by staff.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately and correctly. Staff told us consent was mainly verbal for procedures such as suturing. We did not see examples of patients who did not have capacity to consent to their procedure, but we were able to speak with staff who had access to guidance and an understanding of The Mental Capacity Act 2005.

Mandatory Training

- We looked at staff mandatory training records. These were managed by the lead for each 'mentor group', with a lead band 7 nurse being responsible for ensuring their allocated staff were up to date. Review of the training

records on the intranet confirmed that all nursing staff were up to date, or were flagged if an update was required within three months. The department matron kept an overview of the department progress with training, and received weekly reports from the human resources team on progress with appraisals. In the week prior to our inspection the appraisal rate was 86% and nurse training was 76%, with medical staff at 84% for the department.

- Many nursing staff undertook more advanced training in emergency care, particularly the Emergency Care Practitioners (ENP) who undertook extended practices, and worked alongside the consultants during their training and at times when their additional practice skills were being assessed. Staff told us there was good support when they needed to attend external courses as part of their role development.
- For new staff nurses the department ran a '52 week' training programme. This was structured with a workbook, where learning and reflection were recorded, along with sign off for competence in practical skills such as suturing and assessment of patients in the STATing bay. Nursing staff that we spoke with gave good feedback for the programme, and how it had enabled their development towards more senior posts and skills in the department.
- All staff had relevant, up-to-date training in life support, advanced life support and paediatric life support.

Adult and Child Safeguarding

- There were procedures in place to identify children at risk of harm, or monitoring of any child who was already known to social services. We reviewed four sets of patient records where the safeguarding checklist had been completed as required.
- Where any bruising, unexplained fracture, or injury or unusual reason for an injury was noted, this would prompt a review of the child by a paediatrician.
- Where a child was known to social services, staff routinely completed a form, which the safeguarding nurse would review and then follow-up. If there was a concern with a child already known to social services, a more urgent referral would be made to the safeguarding nurse, or where required, a referral to the out-of-hours social services duty team.
- For children with safeguarding concern a discharge summary would be completed by a nurse and doctor in the department to confirm they were satisfied discharge was appropriate.
- Adult and child safeguarding training was part of staff induction, and all staff had had been trained at either level one, two or three for Child Protection dependant on their role. All paediatric nurses were trained to level three.
- Staff we spoke with had a good understanding of safeguarding concerns for adults. Access to information on how to report a concern was available in a folder and displayed on boards in the department.

Mental health

- Patients with mental health issues were assessed using a specially designed 'mental health triage assessment' tool, which enabled a clear decision in terms of the potential for self-harm or harm to staff and others. A level of observation, from red, to blue or green, was confirmed, and the frequency of review was then recorded at regular intervals dependant on the level of risk assessed. We saw evidence of this assessment for two patients and all aspects had been completed.
- During our visit the mental health co-ordinator was seen to provide support to both patients and staff in the department.
- Assessment of patients living with dementia in A&E was less obvious, and staff told us they did not carry out assessments as these were done on the wards when a patient was transferred; but they could speak with the learning disability co-ordinator for advice at anytime, although this was not their remit.
- Child and Adolescent Mental Health Services (CAMHS) had been raised as a concern prior to our inspection, during a CQC review of children's safeguarding at the trust in February 2014. This service is external to the trust, but is key to the safe assessment and treatment of children with mental health issues. Staff reported that things had improved and the contract was being reviewed to ensure timely access, but at times this was still difficult. Referrals had to be made by 10am for a same day review, which could lead to a delay dependant on when a patient arrived in the department. We saw staff in the Children's A&E dealing with a patient with mental health issues and on this occasion the response from the mental health team was prompt.

Good

Accident and emergency

Major incident awareness and training

- Staff that we spoke with told us that the hospital security staff practise 'lockdown' regularly, and that the hospital could be secured in the event of a major incident / CBRN incident. The emergency planning officer had knowledge and experience of attending emergency table top exercises, which included a chemical, biological, radiological or nuclear element (CBRN).
- We saw that A&E did not store major incident triage cards. During a major incident, any patients self-presenting (perhaps not already triaged at scene by the ambulance service) could not be triaged in a common manner. It was confirmed that in this situation patients would be added to the IT system immediately.
- While staff received 'in house' training for major incidents and decontamination incidents, we were told that no staff had any external major emergency management training. The emergency planning officer described appropriate high level major incident planning (such as inter-agency planning), but this was not corroborated by the knowledge of nursing staff in the department.
- The trust had systems in place to deal with contamination incidents; however, this was not easily accessible in the event of an incident. We were told that all the required protective clothing and equipment was stored in a locked container away from the department. We checked how easy this was to access and found that the store was behind an area blocked off by metal barriers due to building works. The area where a patient would be decontaminated in the event of a chemical or biological incident was not easily accessible from A&E, as it was at the rear of the hospital site. There was no plumbing outside A&E for the decontamination tent, and any patient would have to be walked around the building posing a risk of exposure to staff and the public en route. The Civil Contingencies Act (2004) does not stipulate where a hospital should site decontamination facilities. However, with current arrangements there appears to be no safe way to carry out immediate decontamination without significant risk of further contaminating the staff, patients and visitors in and around the hospital.
- A&E had a 'decontamination room' which could be used in appropriate lower level incidents. We were told that this drained into a closed drain, but staff were unable to confirm the arrangements for monitoring or regular emptying. The room did not appear to have a closed ventilation system, which posed a risk that any substance which formed an aerosol from a patient could enter the main department. We did not see that staff had access to the appropriate protective clothing in the department for use in this room.

Security

- Security staff were not based within the unit, but would visit at regular intervals during the 24 hour period as part of their rounds. They were able to provide additional support for nursing staff where patients required one-to-one observation due to actual or potential violence and aggression. Staff commented that they were easily available when required. We witnessed support being provided in an unobtrusive manner so as not to instigate or escalate violent or challenging behaviour.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The A&E department had an ongoing and extensive programme of audit, which included both national and local policies and protocols. Feedback of audit results was regular and co-ordinated via the governance meetings, and all staff were aware of the results.

Medical and nursing staff had access to a range of protcols, some of which enabled nurse-led treatments and prescribing. Regular audit of the nurse-led protocols was beginning to be implemented.

Department staff were aware of specialist practitioners, such as the trust safegaurding and learning disability leads, who were accessed for guidance and support when required.

Use of National Guidelines

- The A&E department used a combination of National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with this, and were updated every

one or two years, or if national guidance changed. The department ensured that A&E was managed in accordance with the principles in 'Clinical Standards for Emergency Departments' (CEM).

- At the monthly departmental meetings any changes to guidance, and the impact that it would have on their practice, was discussed. Consultant staff told us that there was excellent local engagement with local and national audits, and trainees were encouraged to undertake a clinical audit to assess how well guidelines were adhered to. Information on audits completed was displayed within the department, such as the sepsis audit. Audits were in progress for management of asthma in children and paracetamol overdose. Completed audits were presented to the monthly departmental meeting with discussion and with clear action plans indicating what improvements need to be made as a result of the findings.
- Guidelines for the treatment of children having a seizure was via use of medication in the cheek (buccal), which is a recommended quicker and less invasive route. Use of diamorphine intra nasally for pain relief in children was used in line with national guidelines.

Outcomes for the department

- The unit contributed to CEM audits – including pain relief, where training and education had taken place and a re-audit was in progress.
- Unplanned re-attendances for the department in the last year were between 1.90% and 2.5 %, which was below the target of 5% set by the CEM.

Care Plans and Pathway

- There were documented pathways for a range of patient care issues. These included a mental health triage assessment tool used to determine the urgency of assessment and treatment of patients presenting with mental health problems. We observed this in use and saw how it enabled staff to ensure the protection of the patient, themselves and others, in a safe environment. The department was supported by the mental health liaison nurse, who was readily accessible, with all staff being aware of how to contact them both in and out of hours.
- There were specific pathways for certain conditions – for example, sepsis, community acquired pneumonia, Acute Cardiac Syndrome, renal colic and head injury.
- On the Emergency Care Unit (ECU) patients with less acute conditions were seen in clinics run by advanced nurse practitioners (ANPs), who had advanced training in diagnosis and treatment. There were specific guidelines and pathways for conditions such as deep vein thrombosis, headache and cellulitis.
- While we saw evidence that some pathways were audited regularly, such as sepsis, there was not a formal audit of the pathways used by the ANPs. We were told that some data collection had been commenced which needed to be further developed to demonstrate patient outcomes.

Multidisciplinary Team working and working with others

- Specialist nurse input was available to staff in A&E and ECU via the Mental Health Liaison Team and the trust Mental Health Co-ordinator. The trust lead nurse for learning disability was well known to the staff, and all were aware of how to contact them. Information about meeting the needs of patients with a learning disability, and the service provided, was displayed in the department and supported the 'This is me' booklet, which was used to gather relevant and important information for patients with a learning disability.
- Input from psychiatric teams was available via the trust mental health liaison nurse, who we saw had reviewed a patient in the department and was supporting staff to enable their discharge. External mental health services were provided by the local NHS Mental Health Trust. At times there had been difficulties in accessing timely support from the provider of this service. This was logged on the department risk register, and regular updates were recorded.
- The department and ECU was supported by physiotherapists and occupational therapists (OTs), who were able to provide assessments for patients who were able to be discharged, but required OT support and possibly a home visit the following day. This speeded up review and also prevented avoidable admission to the hospital.

Equipment and facilities

- There was appropriate equipment to ensure effective care could be delivered with access to a range of equipment in the department. The matron did, on occasion, have difficulty in securing work to be completed by the estates team. This was an external contract which was described as 'long winded' to access. At times of urgent need the matron would contact the estates manager directly.

Good

Accident and emergency

- Replacement of some equipment required a business case, such as with the replacement of a number of trolleys. Plans to forecast replacements for the coming year had been put in place, with cardiac monitors, drip stands and electrocardiogram (ECG) machines being identified for replacement.

Seven day services

- Pharmacists were in the hospital from 8am until 1pm on both Saturday and Sunday. Out of those hours there was an on-call pharmacist available on the phone.
- The trust A&E improvement plan highlighted variable access to out-of-hours radiology support, with this being addressed to resolve and reduce waiting times.

Are accident and emergency services caring?

Good

Overall the Accident and Emergency Department provided a caring and compassionate service.

Staff were attentive to patients needs and treated them with respect. There was mixed feedback from patients who had used the service prior to our inspection, and it was clear that when the department was busy patients may feel staff did not display a caring attitude at all times.

The department had responded to meet patients needs through provision of the 'patients pantry', which enabled breakfast, snacks and drinks to be available when there were delays in transfers to wards.

Compassionate Care

- Prior to our inspection, the Patients Association carried out a survey of patients who had used the Royal Berkshire Hospital in the past year. The results of the questions in the survey that related to A&E were mixed, with some patients commenting that staff were responsive and dealt with them quickly despite being very busy. Others felt misinformed and that they had not been treated quickly, or given sufficient information about their condition or course of treatment.
- Despite staff often being busy we saw them respond to patients and their relatives in a caring way and taking time.
- On one occasion, we saw staff responding to a carer who was accompanying a patient with communication difficulties. Staff reacted promptly, enabling the carer to be with the patient at all times to reduce any anxiety, and also to assist staff to understand.
- Where a patient was concerned about the risk of infection due to their condition, staff promptly moved them to a side room and reassured them.
- One family told us how their relative had been given some lunch, as they had missed breakfast and would not be admitted to a ward in time for lunch.
- The Friends and Family Test in December 2013 reflected 959 responses about A&E, 61% were extremely likely to recommend the service, 27% likely and 4% unlikely.
- The department had an action plan to respond to and address issues and concerns raised in the Friends and Family Test. One of these was enabling patients and their relatives to give immediate feedback on their experience by putting a 'token' into a box. These boxes were secured to the wall near the triage room and were based on the 'friends and family' statements of whether a patient would be likely to recommend the department to others. Take up was variable, as staff aimed to give patients a token at the end of their treatment; however, they acknowledged that this did not always work and they had to have a supply of tokens in their pocket and give them out at the right time, otherwise they would be found left on couches, chairs and in other areas. Despite this, all felt it was worthwhile and persevered in giving out tokens and reminding patients about the existence of the boxes.

Patient involvement in care

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- Parents accompanying their children in the Children's A&E were positive about the treatment their child received. One family had attend on several occasions and said that each time they were involved in decisions. Another family said they had been looked after well and kept informed.

Emotional Support

- We witnessed staff explain to a relative the treatment that their sick relative had whilst in the resuscitation bay, which was dealt with in a calm and caring way.

Good

Accident and emergency

- Where staff may have treated critically unwell patients, they said they felt very supported by the wider team with debriefings and time to discuss.

Are accident and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

The Accident and Emergency Department requires improvement in its ability to respond to the needs of patients at all times.

There were a number of reasons that led to patients breaching the four hour target, which included lack of a bed available on a ward, delay in A&E review, delayed speciality review such as to a surgical team, delay in transport, or clinical reasons for the patient remaining in the department longer. In February 2014 the majority of A&E four hour breaches were due to a lack of bed to transfer the patient to on a ward; with 11 patients being delayed for 12 hours or longer. Waiting for mental health assessment (from an external organisation) and specialty review (medical and surgical) were other consistent reasons.

It was clear that the limitations of the available space in A&E had an impact on the ability of staff to be able to meet the four hour target for treatment or discharge. Once capacity in the STATing bay and the majors cubicles was reached, the department soon found itself with an overflow of patients in the corridors. This placed staff under pressure and led to anxiety for patients and their relatives.

Much work had been done to review the exiting pathways and flow within the department, and work was also underway with other local providers and commissioners to ensure that the whole local health economy was focused on admission avoidance and smooth flow of patient discharge. However, a trust-wide systematic approach to the discharge of patients to make beds available for emergency admission did not appear to be robust in its focus on A&E. The daily bed meetings did not appear to focus on the predicted number of admissions to A&E and planning was not proactive or supportive of A&E, as additional bed meetings were only held when the situation was raised to a red or black alert. This lack of forward planning may have led to unnecessary delays.

Support was available for patients with learning disabilities, but staff were not clear on how to access advice and support for patients living with dementia. The unit had a learning disability champion, and they were responsible for ensuring staff were appropriately aware of how to meet patients' needs and assessment.

Performance

- Since April 2013, the trust had not consistently met the A&E national four hour access target, and had been placed under review by Monitor and NHS England, with a requirement to deliver actions and sustained improvement along with a prediction of when the target would be consistently achieved.
- Performance was variable across the year, with April 2013 showing the four hour target for adults was 84%, September 93% and February 2014 85%. The target for children had been achieved throughout the same period. While the adult target was met on some days and weeks, there were no complete months when the adult four hour access target was met, although the target for children was met every month. The combined overall four hour access target varied between 89% and 97% with the majority not meeting the 95% target. The number of daily patient breaches varied hugely from one to 79, with the number of patients seen in the department varying from 205 to 323.
- There were a number of reasons that led to patients breaching the four hour target, which included lack of a bed in a ward, delay in A&E review, delayed speciality review such as to a surgical team, delay in transport, or a clinical reason leading to the patient remaining in the department longer. The trust provided a breakdown of the reasons for breaches in February 2014: Of 294 breaches, 189 were due to a lack of bed to transfer the patient to on a ward, with 11 patients being delayed for 12 hours or longer. Seven patients waiting mental health assessment or review from an external organisation breached the four hours, and 28 were delayed due to a speciality referral, covering a mixture of medical and surgical specialities.
- The number of patients in the last year who left the department without being seen ranged from 2% to 3.5%, which was below the national target of 5%.

Good

Accident and emergency

Maintaining flow through the department

- The A&E department had originally been built to provide clinical space to see and treat 65,000 patients a year. Over time this had increased to the current position of 100,000 a year, which was recognised to pose a risk of overcrowding.
- During 2013, the department had been supported by the Emergency Care Intervention and Support team (ECIST), who work with the A&E department to help identify areas for improvement in the flow and management of patients. The view that significant operational pressures from the flow within the department would lead to associated clinical risks to patients, directed the trust to strengthen strategic decision-making, and establish clearer corporate standards for the emergency pathway. It was acknowledged that this would require drive and direction from the trust executive team, in conjunction with the leadership of the Urgent Care group.
- After the initial visit, issues with delays in the discharging of patients from wards across the hospital was identified as having an impact on the ability of A&E to meet the four hour target, and to ensure patients were admitted in a timely way. There were also concerns that a delay in surgical teams reviewing patients was leading to delays of up to six hours for full assessment of patients. An action plan, detailing the key changes, had been put in place, and had resulted in the setting up of the STATing bay and the configuration of the ECU.
- We saw that despite the STATing bay being in operation, many patients still had to 'double queue' in A&E; this meant that they were assessed on arrival at the door from the ambulance crew, but had to be placed in the corridor queue before going to the STATing bay. Having been assessed in the STATing bay, they would be put back in the corridor queue to wait for the next cubicle to become free on the majors side. To try and keep track of patients, we saw that they were being given a laminated piece of paper which indicated if they were waiting to be seen in the STATing bay. At busy times this had the potential for confusion. We spoke with one patient who had been seen in the STATing bay, but still had a laminated sign to say they were waiting to be seen in STATing.
- Consultant geriatricians were present in the department from 8am to 8pm seven days a week in order to prevent unnecessary admissions.
- The department engaged with the rest of the hospital via the daily bed meeting, where wards reported planned discharges so that available beds were identified for A&E. These meetings only took place more frequently at times of red or black escalation to review the situation. We heard the site team ask how many patients were waiting for a bed in A&E at the time of the meeting (at 9.30am), and this was reported to be seven. The discussion appeared to be reactive, rather than a planned approach about the predicted number of admissions from A&E which may require a bed later in the day or night. It appeared that there was a disconnect between the pressures in A&E and how the strategy to handle the flow of patients in the hospital was managed effectively.
- A bed for a patient was allocated by staff on AMU as they became available. The bed would appear on the A&E overview screen on the computer, several of which were positioned in the staff base. We were told there was not usually a phone call to say that a bed was available and it was the responsibility of the nurse co-ordinator to communicate to staff that a bed was available, although this could be noticed by other nursing and medical staff.
- The ECU was established for A&E patients that were not planned to be admitted to the hospital, but who may require to stay for up to 24 hours. This enabled tests and investigations to be undertaken, and aimed to reduce the number of patients in the A&E department and provide a better environment for patients.
- The Observation ward situated within the department was reported to be used for patients with mental health issues, where they could be assessed away from other patients in the department. During our inspection we checked the type of patients in this ward, and on three occasions it was used for patients who did not have a mental health issue, thus potentially limiting staff ability to provide a suitable environment if a patient with mental health issues attended the department.
- This ward had space for three hospital beds with access to a toilet. We were advised this was a ward area used for assessment of patients with mental health problems, and was not considered to be the same as a cubicle where the A&E four hour target for arrival to discharge, transfer or admission applied. Though only designed for three, on one occasion we saw four patients present in this ward. Three patients in beds and one sat on a chair.

At this time three patients were female and one male; therefore their privacy and dignity was being compromised. This ward only had a one toilet and no facilities for a bath or shower.

- The trust was proactive in working with their commissioners and local GPs across Berkshire through the 'urgent and emergency care and recovery plan', which had identified a range of measures and initiatives for a system-wide plan to reduce the high number of attendances at A&E, and to achieve improvements in meeting the four hour target. It was recognised that the multi-agency approach was critical in having an impact and improving the patients' journey. Actions for the trust focused on timely discharge planning, patient flow, continued use of ANPs, and out-of-hours services to support all care pathways. The regular reporting, review and oversight by the programme board was in place, which also reviewed the trusts existing action plan, developed with support of the Emergency Care Intervention and Support team (ECIST) in 2013. It was recognised that there was much work to do and that some work was in its early stages.
- The department had an escalation plan which was based on the trust capacity risk assessment, and detailed the response by the trust and ambulance trust, and community providers, when the level of escalation was green, amber or red.

Handover process to wards

- Patients in the main were transferred from A&E to either the ECU or Acute Medical Unit. Patients were accompanied from the department by a nurse, who would provide a handover to the staff on the receiving ward.

Meeting the needs of all people

- Support mechanisms were in place for patients with a learning disability; there was access to staff who could communicate using Makaton and information available in easy read formats. Support was available for patients with learning disabilities, but staff were not clear on how to access advice and support for patients living with dementia. The unit had a learning disability champion, and they were responsible for ensuring that staff were appropriately aware of how to meet patients' needs and assessment.
- The department had seen an increase in the number of patients with mental health needs attending, which had been discussed at the department governance meeting in January 2014. The concern focused on the unsuitability of the observation ward, as it was cramped and lacking in privacy; a business case was being developed to provide improved provision for these patients.
- There were a range of leaflets available for different conditions; however, we did not see any evidence of information about the departments, or patient leaflets, being available in any language other than English. There was no information on access to translation services for patients or their relatives. Staff we spoke with across the departments were unsure how to access translation services. Some thought there were information leaflets in different languages on the intranet, but on checking, these could not be found. Most staff felt that there were not issues surrounding this lack of provision, as the majority of patients spoke English and few had cause to seek translation services support. One member of staff had accessed a telephone translation service which was available 24 hours a day. They reported that it had been useful.
- The Paediatric A&E would often see children with long-term and complex needs. In order to be able to provide prompt and appropriate care and treatment in the event of an emergency, a copy of their care need pathways was kept in the department for staff to refer to. This ensured appropriate treatment could be given quickly.
- Relatives who needed to be close to patients who were seriously unwell, or in the resuscitation bay, were able to use the relatives room, although this was small. Staff told us that there were plans to make the room more comfortable, with more homely furniture. We saw that spare chairs were being stored inside the room, which made it appear to be an area in which to put items, rather than a dedicated relatives room.
- The Red Cross charity provided a service to the department when elderly patients needed support to be discharged home. The service operates seven days a week between 2.30pm and 10pm, and took referrals from nursing staff and occupational therapists. They provided transport to take patients home and ensured they were safe, had heating and food, and settled them at home.

Good

Accident and emergency

- The A&E department had a 'patients pantry' and were able to provide drinks, breakfast and snacks during the day. Staff said this had been welcomed by patients and their relatives, especially at times of delay in transfer to wards.

Communication with GPs, other providers and other departments within the trust

- A discharge summary was sent to the GP by email automatically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken.
- There were protocols for the referral of patients to specialist teams, such as orthopaedic and surgery, although these were dated some five to ten years previously. Consultant medical staff explained the difficulties in getting a surgical review for patients, due to the surgeons being in theatre, and therefore not able to come to the department, which led to delays. A recent audit continued to show delays of up to six hours.
- The advanced nurse practitioners (ANPs), who ran clinics for patients with conditions such as deep vein thrombosis (DVT), had regular liaison with GP practices, to ensure patients received daily injections, and that any blood tests required were booked and confirmed.
- The South Central Ambulance Trust had a liaison officer based in the A&E department; they provided a communications link between their service and the staff on duty, to highlight and identify any issues, ensuring information was passed between the teams.

Complaints handling (for this service) and learning from feedback

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, then they would speak to the shift co-ordinator. If the concern was not able to be dealt with satisfactorily, they would be directed to the Patient Advice and Liaison Service (PALS). Any issues raised with the PALs team would be dealt with within a day, for timely resolution. If concerns remained following this, they would be advised to make a formal complaint. The process was outlined on posters throughout the department, but there was no information displayed or any leaflets available on how to make a formal complaint.
- The matron for the A&E department received all of the complaints relevant for the unit. It was recognised that concerns over staff attitude had been raised, which were more prominent during the periods when the department had been very busy. At these times staff limited the number of relatives accompanying a patient to only one, due to space restrictions, and this often caused anxiety and led to some complaints. Actions to address these concerns had included customer service training for staff, and identifying where the tone of staff interaction could be misjudged.
- Complaints were investigated by the matron or other senior staff in the department. The process would include speaking with staff involved and recording the events. Staff told us they would aim to speak with staff as soon as possible after a verbal complaint, so that it could be resolved and patients' needs met. Each senior nurse in the department had a small group of staff to manage and mentor, and they used these groups to discuss complaints, and how similar situations could be prevented. It was acknowledged that at times when the department was very full and busy the number of complaints would rise, as patients expectations were not met in terms of waiting times, although it was felt these had reduced recently.
- Feedback from patients, and the actions taken as a result, were displayed in the A&E department on a 'You said, we did' board. Some examples included introducing a uniform for doctors, so they could be easily recognised from other staff, and the introduction of the STATing bay, to ensure that patients were seen for an initial assessment more quickly.

Are accident and emergency services well-led?

Good

The A&E department were proactive at identifying and improving areas that were within their control.

Staff at all grades and levels in the department were proud to work in a highly supportive and cohesive team, which placed patient care at its centre. Interaction between all grades was timely, and access to advice and support was evident at all stages of the patient journey.

Processes for reporting and reviewing performance were established, with governance meetings held monthly.

Leaders in the department were open and approachable, taking the opportunity to involve all staff in decisions, such as the developments of the STATing bay, which resulted in prompt initial assessment of patients.

More junior staff were encouraged to learn and develop in their role, with a network of group mentorships promoting opportunities for all.

Leadership of service

- The department was led by a lead consultant and matron, with a deputy matron for A&E, the ECU and Paediatric A&E. Staff were organised into 'mentor groups', where a band 7 nurse was responsible for a number of registered nurses and healthcare assistants. This ensured that responsibility for overview of training and supervision was clearly defined, and channels for communication were well established. Staff mentioned the mentor groups to us on a number of occasions, and it was clear that these worked in a supportive and open manner. All people in lead roles were highly visible around the department and ECU during our inspection.
- For band 6 and 7 staff nurses there was a system of 'buddying' to support their management and leadership skills, which was reported to be effective.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility, and all staff worked across A&E and ECU, which enabled an appreciation of the all of the aspects of the emergency department pathway.
- Openness and honesty was the expectation for the department, and was encouraged at all levels. Staff repeatedly spoke of a flattened hierarchy and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care.
- Staff particularly felt supported at times of serious emergency cases, with debrief sessions being held as soon after the event as possible, and openness regarding how the event was dealt with and any learning that could be taken forward. Student nurses were included in this by the consultant staff, who ensured that they explained process and actions at all stages of dealing with an emergency.
- Feedback from student nurses who had been on placement in the department was high, with comments that they had been made to feel part of the team and that staff ensured they were able to be involved in all aspects of patient care and treatment.
- Staff knowledge of the executive and the trusts more senior management was patchy, and there appeared to be lack of visibility of these levels of staff in the department.

Vision and strategy for this service

- The department vision was for a single point of access for patients, and there were active discussions about safety versus bed pressures. However, staff reported that this was not enabled by the rest of the hospital.
- There were plans in place to work with the local Clinical Commissioning Groups (CCGs), to have a system-wide approach to reduce the number of A&E attendances, but these were not in place or confirmed at the time of our inspection.

Governance, risk management and quality measurement

- Monthly governance meetings were held within the directorate, which were attended by medical staff and senior nursing staff. Minutes we reviewed demonstrated a core of regular attendees and others who were attending for specific items.
- The meetings covered a range of areas, such as complaints, incidents, audits and quality improvement projects. The departmental risks and compliance with CQC standards were discussed, along with the outcomes and learning from incident investigations. Feedback to other department staff was via the 'mentor group' through debriefs, one-to-one meetings and emails, usually within a month of the meeting or of an investigation being completed.
- The top risks identified for the department were management of patients with mental health needs, capacity, the physical environment and the impact that this had on privacy and dignity.
- Representatives from the department attended other governance meetings in the Urgent Care directorate to ensure sharing of issues, and joint working across the wards and departments. Where there was a need to raise any issues at the governance meeting for other directorates, this would be on request via the chair of those meetings, such as for surgery and the Planned Care directorate. While the department was reported to

work well, there was a view that the directorate care groups did not work in collaboration, with 'silo' working being described which was not conducive to shared visions or learning.
- Senior nursing staff were able to access the professionals group meeting for nurses, and attend the grand round where clinical cases were discussed for learning and dissemination.
- The departmental key performance indicators (KPIs) were monitored against other trusts, and displayed each month. Indicators for clinical care, cellulitis and deep vein thrombosis (DVT) were good.

Innovation, learning and improvement

- Innovation was encouraged from all staff members across all disciplines. All grades of staff were involved in quality improvement projects, and staff were able to give examples of practice that had changed as a result; the most recent project being the introduction of the STATing bay, which all members had contributed to, from the planning stage, through to the evaluation.

Requires improvement

Medical care (including older people's care)

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

Information about the service

Medical provision at the trust included 16 permanent wards, which includes a 42-bedded acute medical unit (AMU). It also includes eight escalation beds, which are located in the emergency care unit, and medical patients who are treated on surgical wards.

We visited 13 of the hospital's medical admission wards, including the AMU, acute stroke unit, and the cardiac care unit. We also visited the following inpatient wards: Adelaide, Adelaide Annex, Burghfield, Castle, Caversham, Emmer Green, Hurley, Redlands, Sidmouth and Victoria. We also visited the trust's dialysis unit in Windsor, which is one of the two satellite dialysis units.

We talked with 42 patients, five relatives and 82 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultants, doctors, junior doctors, pharmacists, allied healthcare professionals and management. We observed care and treatment, and looked at 25 sets of patient records, including medical and nursing notes, and 28 drug charts. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall the cleanliness and hygiene on the wards was adequate, although some areas fell below expected standards. Nurse staffing levels were at times insufficient with a reliance on bank and agency staff. This was particularly on wards for older people, including wards where elderly patients were not always placed on the most appropriate ward for their needs, due to capacity pressures. Whilst training was available in dementia care, many staff had not attended and some were unaware of the availablity of training.

We were told that a shortage of medical cover out of hours and during weekends, delayed care and discharges. The hospital did have a hospital at night team to improve care out of hours. Patients were kept on medical wards long after they were assessed as being medically fit for discharge. There were notable lapses in medicines management, with insufficient understanding of drug storage requirements.

Clinical data was not always easily accessible due to the fragmented structure of the trust's electronic patient record (EPR) and patient records were not well maintained with an over-reliance on 'temporary' records. There were standardised care pathways and care plans, but these were not consistently used.

Medical wards were compassionate and caring, with good leadership on the majority of wards.

Requires improvement

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We found that significant improvements needed to be made to medical services to ensure that is was safe for all patients at all times.

Nurse staffing levels were not sufficient on some wards, particularly those caring for older people and consequently the hospital relaied on bank and agency to staff the wards. There were consultant led ward rounds at the weekend for some specialties. There were significant concerns regarding medical records. Old medical records were not easily available, which led to an over reliance on 'temporary' patient records and resulted in decisions about care being made without the patients full past medical history and previous care. The electronic patient record was fragmented and a lack of computers meant that staff were not able to input clinical data onto the system in realtime.

There were widespread lapses in the medicines management, with a particularly poor understanding of drug storage requirements. There was little understanding amongst nursing and clinical staff of the Mental Capacity Act 2005. Mental capacity assessments were not consistently undertaken where required, and formal best interest decisions were not conducted on behalf of patients who lacked capacity to make decisions. There were patients living with dementia on almost every ward we visited, but staff did not have training in caring for people living with dementia.

Cleanliness, infection control and hygiene

- Overall standards of cleanliness and hygiene on the wards we visited were adequate, although some improvements were required.
- Cleanliness was not a KPI (key performance indicator) on the wards monthly KPI report. The matron monitored cleanliness monthly and issued performance certificates to the wards.
- Toilets and shower facilities were surface clean, but on some wards, particularly Caversham, we found mouldy and peeling paint, rusty radiators, and inadequate water drainage for the shower. We found faeces on the floor of a toilet and shower room on Adelaide.
- Television arms were very dusty on all the wards we visited. Cleaning standards on Sidmouth were poor and side rooms in AMU were not always clean.
- Window blinds on Hurley were dirty.
- Staff did not always record the date on which cannula were inserted, which meant staff did not know when to remove them. The failure to record the date on which cannula are inserted puts patients of risk of developing infections from cannula which are in situ for too long.
- Staff told us that they had infection control training and were supported by infection control 'champions'.
- We saw staff regularly wash their hands, and they wore gloves and aprons when appropriate.
- 'Bare below the elbow' policies were adhered to and audited.
- Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed.
- The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and C. difficile were within expected limits when compared to trusts of similar size and complexity.

Nursing Staffing

- Nursing numbers were assessed using a nationally-recognised staffing acuity tool.
- We spoke to staff and patients about staffing levels and looked at rotas. We found that there were adequate numbers of staff on some wards, but other wards, were often short-staffed due to vacancies and the trust aimed to staff these through the use of bank and agency staff.
- Staff on Emmer Green and Burghfield, both elderly care wards, told us that the wards had been significantly short-staffed, but that new nurses had recently been recruited following a staffing review in August 2013. Approximately 50% of nursing staff on both these wards were new. They stated that, despite increased staff levels, the rotas were not always filled.
- On one morning, we observed that Emmer Green was so short-staffed that medicine rounds, breakfast, and bed baths were significantly delayed. Staff told us that this was due to two nurses ringing in sick and agency staff were called to start work later in the morning.
- Concerns about staffing levels were noted in the minutes of the elderly care department's clinical governance meetings.

Requires improvement

Medical care (including older people's care)

- Staff across all the wards we visited told us they were encouraged to ensure that each shift had a full complement of staff, but that sometimes getting staff, even agency and bank staff, was a challenge.
- When particularly vulnerable patients needed one-to-one care, they were usually provided with a nurse or a healthcare assistant to look after them. Staff told us they were usually supported to get additional staff when one-to-one care was needed.
- Across all the wards we visited, there was a high reliance on bank and agency staff to fill vacant shifts.
- Agency and bank staff told us they had inductions, and their credentials were checked. Evidence of completed induction checklists were signed by staff. We found, however, they were not always familiar with procedures and could not always find things when asked.

Medical Staffing

- Staff told us there were sufficient consultants and doctors on the wards during the week, but there was a shortage of senior doctors out of hours and at weekends. They said this resulted in patients sometimes having to wait long periods of time for treatment or care; for example, to be admitted to the chest clinic or to have their prescriptions written up prior to discharge.
- During one of our visits, which was overnight at the weekend, we found there were three junior doctors and one registrar on duty for the whole of the hospital's medical wards, including the AMU.
- At one point, one of the junior doctors had 60 patients waiting for them to sign off on prescription antibiotics and intravenous fluids.
- The hospital at night team consisted of two outreach nurses and an assistant practitioner until 2am. After 2am there was one outreach nurse and one of the junior doctors would support them in covering the medical wards.
- The consultant ward rounds we observed were well managed and thorough. Junior doctors felt well supported by senior doctors, and told us that consultants were contactable by phone if they needed support out of hours.
- The only exception was on Adelaide, an oncology ward, where we found consultant ward rounds were erratic, unorganised and unplanned. There was no agreed schedule for consultant ward rounds and no structure for them. There were daily ward rounds which included senior doctors, but consultant ward rounds did not take place regularly. There were insufficient registrars to support junior doctors on the oncology wards. We were told this was because they were often busy supporting clinics elsewhere. Junior doctors did not feel they were well supported by consultants.
- The hospital had two permanent wards that staff referred to as escalation wards, called Redlands and Hurley, which had been made permanent wards to increase inpatient capacity. There were no substantive trust medical staff assigned to provide cover to Redlands; staffing consisted of one locum consultant general medical physician and two locum senior house officers who worked in isolation from the rest of the trust. We were told that when the locum consultant or senior house officers were away, there was no cover on the ward.
- No arrangements were in place for the locums to link with or get support from other teams, and information from incidents, complaints, and audits were not shared with them. The consultants on AMU were allocated to provide medical leadership and support to the locums on Redlands but we were told that this did not consistently occur.

Management of the deteriorating patient

- Medical wards used a nationally-recognised early warning tool to identify deteriorating patients.
- Staff could tell us the protocol they followed when a patient deteriorated. Patient records we looked at showed that the protocol was followed.
- Staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- There was a critical care outreach team which supported ward staff in managing deteriorating patients. Staff across all wards praised this service highly for its responsiveness and support.

Nursing and Medical Handover

- We observed both medical and nursing handover, in and out of hours. They were well attended and thorough. Staff showed good knowledge of patients on their wards, and patients at risk of deterioration were identified clearly.
- Nursing handovers occurred at the change of shift. Staffing for the next shift was discussed, as well as any potential issues.
- Medical handovers at night took the form of a 'Hospital at Night' meeting at 10pm. All the on-call team for the

day and night attended (except for consultants). In addition, the critical care outreach team and the site manager attended. The handover was structured and documented. Attendance was recorded.

Safety Thermometer

- Safety thermometer information was clearly displayed at the entrance to each ward. This included information about falls, new venous thromboembolism (VTE), catheter use with urinary tract infections, and new pressure ulcers.
- The trust was performing within expected ranges for falls and pressure ulcers, but had higher number of patients suffering from new VTEs and new urinary tract infections (UTI) than the England average.
- Risk assessments for the above were completed appropriately on admission, and care bundles were in place for falls, pressure ulcers and catheter care.
- Audit data from December 2013 provided by the trust showed patients were not always assessed for falls within the four hour target. This was a particular concern on Emmer Green and Castle wards. The data also showed falls care bundles were started, but not often completed on many of the hospital's medical wards.

Incidents

- There was one 'never event' in the medical division, which occurred in November 2013. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented.)
- This involved the insertion of a naso-gastric (NG) feeding tube and led to a full root cause analysis investigation. The results of the investigation were fed back to staff, and staff we spoke with were able to tell us what had changed as a result of the 'never event'.
- We noted, however, that the investigation found staff did not recognise the incident as a 'never event' and so did not report it as such. When we spoke to staff about the incident, we found a continued failure in their understanding and ability to identify it as a 'never event.'
- Staff we spoke with stated that they were encouraged to report incidents, and received direct feedback from their ward manager about investigation findings.
- Themes from incidents were discussed at monthly meetings, and staff were able to give us examples of where practice had changed as a result of incident reporting.
- When we looked at patient records, we found that incidents were usually reported, but we also found evidence of instances where falls and medication errors were not reported.

Environment and equipment

- There were poor storage arrangements on some wards, particularly Caversham, Sidmouth, Burghfield, and Redlands, which resulted in a large amount of equipment cluttering the corridors, making the wards difficult to clean, and putting patients at risk of cross infection.
- On Redlands, we found both fire exits and one set of fire extinguishers were inaccessible due to being blocked by equipment. Staff told us this was because there was nowhere else to store them.
- In the treatment room on Burghfield we found the smoke detector on the ceiling was covered by a blue disposable glove and the air vent was covered in duct tape. Staff were unable to tell us why.
- On Adelaide and Caversham wards we found that some shower rooms had an adverse camber, which meant that water pooled in puddles on the floor or leaked out into the corridor. Staff on Caversham said they had reported the matter several weeks ago and it had not been addressed. Inadequate drainage poses a falls risk, and also a risk of cross infection between patients. The risk of infection was of particular concern on Adelaide, where patients receiving chemotherapy have weakened immune systems and may be more susceptible to infection than other patients.
- In almost all the medical wards we visited, bins full of clinical waste were unlocked and easily accessible to patients and visitors. We found the bins remained unlocked a week after we raised concerns with relevant ward managers.
- Staff told us they usually had adequate equipment for their needs.
- The one exception raised by almost all the staff we spoke with was the lack of available computers to input clinical data. The trust used an electronic patient record system. One of the difficulties staff told us about was that there were too few computers for their needs. They said computers on wheels often broke down and hand held tablets were not fit-for-purpose. We saw broken computers on wheels on three of the wards that we visited.

- A lack of computers meant that staff had to wait in queues to put patient information on the electronic system, or that sometimes the information was not entered at all.
- Staff also said there were long delays in the trust's response to maintenance issues. We were told this was due, in some cases, to difficulty getting parts and, in others, to poor response from the estates contractors.
- We observed several bathrooms and shower rooms across different wards, which were either out of order or required some repair.

Medicines

- Medicines were not always stored securely. This was a particular problem on the Victoria, Adelaide and Sidmouth wards, as well as the acute stroke unit.
- Treatment rooms on many of the wards we visited, with access to needles and IV fluids, were unlocked.
- On some wards medicines were stored in an open area behind the reception desk. When there were no staff at the desk, medicines could be accessed by patients and visitors.
- On Sidmouth, we found Lorazepam injections in an unlocked refrigerator, which should have been locked.
- Drugs trolleys were not always locked or securely stored.
- On some wards, notably Adelaide and the acute stroke unit, drugs trolleys were unsupervised and left in publicly-accessible places. This meant that the drugs inside were publicly-accessible.
- Checks on the temperature of refrigerators used to hold medicines were not done on most of the wards that we visited.
- Staff on some of the wards did not know how to check refrigerator temperatures.
- Where medicines, including antibiotics, were stored in treatment or clean rooms, ambient room temperatures were not monitored. On one occasion, we found the clean utility room on Redlands, which was used for medicines storage, was 33 degrees celsius. Many medicines must only be stored in temperatures up to 25 degrees celsius. Storing them in areas which are hotter than this poses a risk that the medicines will be ineffective. Staff told us that the room was usually very warm and they did not recognise the risks of storing medicines at hot temperatures.
- Oral liquids and eye drops were not marked with the date on which they were opened. For medicines which expired some time after opening, this made it impossible to know when the medicine expired and put patients at risk of being treated with expired medicine.
- We found four infusion bags which were out-of-date on Victoria ward and IV fluids which were inappropriately stored under the sink in the clean utility room on the acute stroke unit. This put patients at risk of receiving IV fluids which were out-of-date or contaminated.

Records

- Patient records were fragmented and often difficult to follow.
- Both paper and electronic patient records were used at the trust, with some information about patients being kept in paper format and some on the electronic system.
- The exact information kept on the electronic system varied between wards. For example, some wards used the electronic system only to record basic information such as a patient's name and demographic details, while other wards used it to record observations and identify deteriorating patients.
- The trust's various electronic databases were not integrated, which meant information about patients was held in different databases that were not linked with one another.
- Paper records on most wards were equally disorganised, with particularly poor record keeping on Redlands and Adelaide.
- On AMU and Castle we found instances where patient records were missing or mixed in with other patients' records.
- Record keeping and templates were not standardised and varied from ward to ward. The way in which patient records were stored also varied between wards. For example, wards stored clinical notes, nursing notes, care plans and discharge plans in different folders. This made it difficult to find patient records and to follow patients' care.
- We also found many wards used 'temporary' patient records for large numbers of patients. Temporary patient records usually accompanied patients during transfer from AMU to another ward. They usually consisted of very basic assessment information.
- Staff told us that the temporary records were intended to be used to provide information about patients until

their full medical records could be located or brought over from AMU, perhaps for a period of up to 24 hours. We found temporary records were often used for more than three or four days, sometimes for weeks.
- Nursing and medical staff told us they did not always have all the information they needed to make appropriate decisions about care and treatment, and this put patients at risk of receiving inappropriate care.
- Risk assessments were documented, nursing and medical notes were adequate, although they were not always dated, timed and signed.
- There were standardised care plans and these were often, but not always, used.
- One particular concern, however, included patient records on Adelaide and Redlands wards. Patient records on these wards were not clear and some important records were missing. Clinical notes did not include clear treatment plans and there was no information about what treatment had been given or what treatment was planned. We found one occasion on Adelaide where a high risk cancer patient was identified as needing an MRI scan, but doctors failed to notice that this was not ordered and so the patient did not have an MRI scan when required.
- Patient information and records were not always stored securely. On one occasion, we found that a doctor had taken a patient's case history, including the patient's name and address, and taped it to a board in the ward's main corridor and in full view of all passers-by. Staff seemed to accept this as normal, and the nurse in charge of the ward told us this was a regular arrangement when the ward was busy.
- On other wards, where side rooms were in use, patient records were stored on a wall mounted bracket placed just outside the door to the room. These were not supervised or locked, and the records could be taken and viewed by anyone walking by.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Where patients had capacity to consent, they were consented appropriately and correctly.
- However, where patients were assessed on admission as suffering from memory loss or confusion, or diagnosed living with dementia, mental capacity assessments were not undertaken.
- Ward staff we spoke with had little or no knowledge of the Mental Capacity Act 2005. Staff told us mental capacity assessments were undertaken by the older people's mental health liaison team.
- Staff told us confused patients were referred to the trust's older people's mental health liaison team and it was this team that was responsible for undertaking mental capacity assessments.
- We found no documented evidence in patient records that patients were referred to or received support from the liaison team. However, the team has seen an increase in referrals over the last year.
- We found some assessment of mental capacity by the occupational therapy team, but this was not always complete, and did not reflect the requirements of the Mental Capacity Act 2005. The failure to undertake mental capacity assessments put patients at risk of receiving care, or having decisions made about their care to which they may not have agreed.
- Best interest decisions were not held when there was a conflict of interest between treatment proposed by clinical staff and the opinion of family members.
- We found examples where relatives were involved in making decisions about patients' care even though there was no appropriate power of attorney in place to ensure their views were taken into account.

Mandatory Training

- We looked at staff training records. The trust had a target of each ward achieving at least 85% compliance with mandatory and statutory training. Records showed that none of the wards we visited met this target, with compliance rates varying with some near to the target and others significantly below.
- Most of the staff we spoke with, however, told us they were up to date with their mandatory and statutory training.
- They also said they had annual appraisals and could tell us when their last appraisal had been.
- Most staff we spoke with did not have training in caring for people living with dementia. The trust did provide training, but staff were either unaware or had not attended.
- This was a particular concern on Emmer Green, Hurley, Victoria, Burghfield and Redlands, where most of the patients were elderly and many of whom were living with dementia.

Requires improvement

Medical care (including older people's care)

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

Good

Medical care was effective, although improvements are required in some areas. National guidelines were reviewed and incorporated into local trust policies and protocols. Outcomes for patients were good, with the trust performing at or above average against key national performance indicators. Consultant input into patient care was good, and there was good consultant involvement in multidisciplinary meetings to review patient care. However, there were concerns about lack of specialist medical support from the cardiology department for patients who were outliers on non-cardiac wards. There were standardised care pathways and care plans, but these were not used consistently. Care plans did not reflect patients' individual needs and were not always effectively implemented. The environment and equipment on most wards was tailored to meet peoples' specific care needs; however, a high demand for inpatient beds and stretched capacity meant that patients were often put in surge beds and escalation wards, which were not always appropriate for their needs. There were particular concerns about the continuity of care for patients who moved from one ward to the other, as key clinical information did not routinely follow patients when they were moved. In some instances, continuity of care was further compromised by an electronic patient record system which was not fit-for-purpose.

Use of National Guidelines

- The medical division used a combination of NICE and other clinical guidelines to determine treatment protocols, and inform trust policies and procedures.
- The use of NICE guidelines was audited and where non-compliance was identified, action plans were put in place to achieve full compliance.
- Local policies were written in line with national guidelines, and were updated when required.
- Changes to national and local guidance, and the impact that it would have on their practice, was discussed at departmental and clinical governance meetings.

Consultant input

- During the week, there were daily consultant rounds on all the medical wards we visited and discussions from these were clearly documented in patients' records.
- Consultants also participated in daily board rounds and twice weekly multidisciplinary team meetings (MDT) to review patients.
- Many of the wards had good systems in place for ensuring continuity of care from consultants. For example, some wards had the same consultants on duty for one week at a time, others for one month at a time.
- There was good consultant coverage of the renal service in Windsor. Specialist renal consultants were based there two days a week and held additional outpatient clinics there.
- Consultant cover on AMU was good during the week, with consultants being on duty from early morning until 10.30pm and 8am to 8pm at weekends. There were daily consultant ward rounds. The time within which newly admitted patients on AMU were seen by a consultant varied from between two to six hours during the day. Patients who were admitted at night were seen by consultants the next morning.
- Once patients were transferred from the AMU to a specialist ward, they were seen by a consultant during the following consultant ward round.
- However, where patients were outliers on medical or surgical wards, they were not always seen by the required specialist consultants.
- Staff raised particular concerns with us about lack of specialist medical support from the cardiology department, for patients who were outliers on non-cardiac wards. They said medical outliers who needed to be seen by a cardiac specialist were ignored because doctors in cardiology refused to visit them. Staff on one of the surgical wards we visited told us about a patient for whom it took a week before a cardiac consultant responded to an urgent referral. The same patient was not admitted onto a cardiac ward until after they had suffered a cardiac arrest. Staff said this was despite numerous attempts to have the patient moved much earlier.

Outcomes for the division

- There were no outliers for mortality associated with medical conditions.

Requires improvement

Medical care (including older people's care)

- Emergency readmissions were within expected parameters, and the standardised readmission rates compared favourably with national rates.
- National clinical audits were completed and results showed that the trust's performance was similar to that of other trusts.
- Data from audits in head and neck oncology, heart failure, dementia, acute coronary syndrome or acute myocardial infarction (MINAP), and the sentinel stroke national audit programme (SSNAP) showed outcomes for patients at this trust were good.
- The trust performed better than the national average for giving patients with signs of heart attack primary angiographies within 150 minutes of calling for help.
- The medical division participated in all but three of the clinical audits in which it was eligible to participate. It did not participate in the adult community acquired pneumonia audit.

Care Plans and Pathway

- Admission processes were clear and care pathways were followed.
- Where risks were identified, care plans were in place to show how the risks were addressed, although there were notable exceptions.
- Patients who were confused or who were living with dementia did not always have care plans in place to instruct staff about how to meet their specific needs.
- Where patient behaviour was identified as challenging, violent, or abusive (as a result of cognitive impairment) there were no care plans to support staff in managing their behaviour. This is a particular concern, both for the safety of the patients involved, but also for that of staff. The 2013 NHS staff survey showed that the percentage of staff experiencing physical violence from patients, relatives or the public, was higher than the national average, which placed them within the bottom 20% of trusts nationally.
- Most care plans we saw were standardised and used throughout the medical wards we visited.
- However, care plans were not used consistently. For example, some patients who had indwelling catheters had care plans for catheter care, and some did not. Similarly for personal care and hygiene: many patients with identified personal care needs did not have a care plan outlining how their personal care needs would be met.
- There were a number of occasions where patients were assessed as being at risk of malnutrition, and food diaries were put in place to monitor their food intake. There were often no corresponding care plans indicating how the risk would be managed and reviewed.
- Patients were not involved in care planning, and care plans were not tailored to meet individual patients' needs.
- Although changes to patients' care were noted in medical and nursing notes, care plans were not reviewed or amended to reflect changes in patients' care or circumstances.

Multidisciplinary Team working and working with others

- Care on every ward we visited was planned and provided by multidisciplinary teams.
- We observed multidisciplinary ward rounds and these were well attended by staff from different disciplines.
- The MDT ward round we saw on Victoria was excellent.
- Patient records we saw showed patients were assessed and reviewed by physiotherapists, occupational therapists and dieticians.
- When required, patients were referred to the pain team.
- There was good involvement of the critical care outreach team in providing advice and support for deteriorating patients on medical wards.
- There was dedicated pharmacy support on AMU, which enabled the ward to process 30% of its TTOs (to take out medicines; medicines which patients take with them on discharge from hospital) within 30 minutes, and significantly speed up patient discharge.
- There was also a strong parenteral nutrition team.
- Staff we spoke with generally praised the support they received from other teams, but raised concerns about support from diabetic and ear, nose and throat (ENT) outreach. They said support from these teams was sometimes difficult to access and there were often delays in the teams' responses. When we looked at patient records, we found some patients who needed a support from a diabetic clinical nurse specialist did not always get the support they needed when they needed it.
- Staff on many of the wards we visited told us about the older people's mental health liaison team. They told us they could access support on mental health and dementia care issues from this team.

Requires improvement

Medical care (including older people's care)

Equipment and facilities

- Staff on almost all the medical wards we visited told us they had sufficient equipment to allow them to deliver effective care to patients. There were exceptions.
- Staff on all wards told us there were insufficient computers to enable them to input and view patient data. They said computers were either broken or not fit-for-purpose.
- Almost all the staff we spoke with criticised the trust's electronic patient record system as having limited value, and being poorly integrated with other electronic databases.
- Medical staff were particularly critical of the radiology and pathology database. They said it was difficult to find patients on the database, and it could not show trends in blood test results or hold electronic images.
- Consultants and doctors told us that the whole of the IT system for returning laboratory results was slow, and this had an impact on their ability to make well informed decisions about patients' clinical care.
- They said there was also no way of recording whether patients have had required tests. This posed a serious problem for medical outliers who were moved from one ward to another, because their test results did not follow them from ward to ward. Instead, patients had to have the same tests three or four times, with some tests taking up to five days to complete.
- According to the trust's complaints team, waiting times for tests was one of the most frequently cited patient complaints.
- Staff we spoke with told us they avoided using escalation areas when they could, and only placed low risk patients in them. They could describe what a 'low risk' patient would look like, for example, an ambulatory patient who was not at risk of falls and who did not have complex needs.

Seven day services

- Services were not always available seven days a week, although some services had been extended.
- Consultant cover on AMU was extended until 10.30pm during each week day and from 8am to 8pm during weekends (two consultants).
- On all the other wards we visited, except Adelaide, there was good consultant presence during normal working hours. At weekends speciality consultants are scheduled to undertake ward rounds in cardiology, renal, respiratory, elderly care and haematology.
- Staff told us that consultants were on-call out of hours and were accessible when required.
- Pharmacy services were available during the week between normal business hours, and on Saturday and Sunday mornings. Out of hours, there was an on-call pharmacist to dispense urgent medications, but TTOs were not processed.
- Occupational therapy services were not available at the weekends for the general medical wards. Physiotherapy provided an on call service and they were available onsite for four hours at weekends each day, however staff we spoke to were not aware of this.
- Support from the older people's mental health liaison team was not provided during the weekend.
- Routine radiology did not run at the weekends, but staff told us that they could get X-rays and CT scans if needed.
- Maintenance dialysis services were available six days per week at the Windsor Dialysis Unit, Bracknall Clinic and Royal Berkshire Hospital (until 11.30pm at Windsor and Royal Berkshire Hospital. Acute haemodialysis was provided at the Royal Berkshire Hospital on the ward.

Are medical care services caring?

Good

Staff on medical wards were compassionate and caring. Staff were clearly focused on the needs of patients and improving services for patients. People we spoke with praised trust staff for being kind and responsive to their needs. Most patients we spoke with felt involved in their care, although there were significant exceptions on Adelaide. Relatives said visiting times were flexible, particularly when patients were unwell. On Adelaide and Emmer Green, we observed relatives were supported to stay overnight. There were rooms on some wards where private conversations could be held with families and relatives. Information from national patient experience data showed good patient experiences in some areas, but improvements are required in others.

Requires improvement

Medical care (including older people's care)

Compassionate Care and emotional support

- The majority of patients and relatives we spoke with were pleased with the care provided at the hospital. They told us nurses and healthcare assistants were caring, compassionate and responded quickly to their needs.
- Patients said they were regularly seen by doctors and felt well informed about issues relating to their care.
- Almost all the patients we spoke with praised the food and menu choices.
- Relatives said visiting times were flexible, particularly when patients were unwell. On Adelaide and Emmer Green, we observed relatives were supported to stay overnight.
- There were rooms on some wards where private conversations could be held with families and relatives.
- Patients praised the staff at the Windsor Dialysis Unit for being compassionate and kind.
- Areas where patients felt the trust could improve included car parking arrangements and signage across the hospital.
- They also felt more could be done to minimise the level of noise on AMU at night, so that patients could sleep undisturbed.
- Most patients told us they received adequate pain relief when they needed it, but some patients and relatives from Adelaide told us this was not always the case. We found one occasion on Adelaide where a patient waited two hours and twenty minutes for pain relief.
- Where patient experiences were identified as being poor, action was taken to improve their experiences. There were examples of this on every ward we visited in the form of 'You said, we did' notices.
- Staff we spoke with were able to describe changes they had made as result of suggestions or complaints from patients or relatives.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. We observed particularly sensitive care on the acute stroke unit and coronary care unit.
- During one of our visits, we found staff on Emmer Green maintained their professionalism and promptly attended to patients and relatives, despite being severely short-staffed and under considerable pressure.
- There were, however, some concerns about privacy and dignity standards in some areas. Bay areas in AMU were sometimes occupied by male and female patients. Staff told us this was due to capacity pressures.
- Night staff across a number of wards told us they were asked by their managers to wash and dress a small number of patients on their wards before 6am to relieve pressure on the morning shift. Staff told us this was usually one patient per bay or patients who were due to be discharged later in the day. Staff told us they were not comfortable asking patients to bathe at this time of the morning, but risked censure from their managers if they did not.
- Generally, patients told us that staff responded quickly to call bell requests. They also said that sometimes nurses acknowledged their requests immediately and responded fully later.
- On two occasions, we observed that it took staff on Emmer Green ten minutes and six minutes, respectively, to answer a call bell. Medical and nursing staff failed to notice the orange lights throughout the ward indicating a call was initiated. They also did not hear the buzzer from the control panel because the sound level was set to 'night' (low sound). On one of these occasions, staff only responded to the call bell because we brought it to their attention. On both occasions, staff failed to check the call bell control panel which showed which call bell had been pulled.
- Information from national patient experience data showed good patient experiences in some areas, but improvements were required in others.
- Results from the Friends and Family Test in January 2014 showed AMU, Redlands and Caversham were the least likely of the trust's medical wards to be recommended by patients to their friends and family.
- The 2012/13 Cancer Patient Experience Survey found the trust scored better than similar trusts for the provision of information about their cancer and the attitude of nurses.
- The trust scored much worse, however, for patients being given information about tests and side effects of treatment, for being involved in making decisions about their care, and pain management.

Patient Involvement in Care

- Patients and relatives from almost all the wards we visited felt involved in their care.
- They said they were given the opportunity to speak with the consultant looking after them, and they were provided with explanations in a way they could understand.

Requires improvement

Medical care (including older people's care)

- They felt they were able to ask questions if they had any, and these were answered.
- There was one significant exception and this was on Adelaide. Some patients on this ward felt their views and opinions were ignored by doctors. They said they were not given clear information about their treatment plans and did not always feel respected by medical staff.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Medical services are responsive to patients' needs, but significant improvements are required. We found the trust faced significant capacity pressures and this meant that, although patients felt well looked after, they were not always able to be placed on the most appropriate ward for their needs. The trust was taking steps to manage patient flow, but we found there remained significant challenges in this area which had an adverse impact on patients. Discharge arrangements needed improvement. Many patients were kept on medical wards long after they were assessed as being medically fit for discharge. In addition, a shortage of care or nursing home beds, and delays in the provision of care packages, meant that many elderly patients were kept in hospital long after they were deemed fit for discharge. Patients who should have had mental capacity assessments did not have these, and best interest decisions did not take place for those without capacity to make decisions about their own care. An interpreting service was available, but was not well known or widely used by staff. There was adequate information to enable people to make a complaint, but improvements are required in the way complaints are managed.

Access

- The trust performed as expected or better than expected against waiting time targets. The trust exceeded its target for referral and treatment times.
- Patient waiting times for diagnostic tests were adequate and within expected ranges.
- Waiting times for diagnosis and treatment of cancer were also within expected ranges.
- The hospital had a high bed occupancy rate, with bed occupancy scoring 89% between October and December 2013.
- We found the hospital faced significant capacity pressures and this meant that, although patients felt well looked after, they were not always able to be placed on the most appropriate ward for their needs. We found patients were staying on AMU, which is intended to be an assessment and short stay ward, for long periods of time, because there were no available beds on other wards.
- There were occasions where oncology patients were kept in AMU because there were no available beds on the hospital's oncology wards. This was a risk because AMU is an exceptionally busy ward, with many patients and relatives coming in or going out continuously throughout the day. The high level of patient traffic increased the risk of spreading infection to patients who had chemotherapy and who were, therefore, susceptible to infection.
- Elderly patients, including those suffering from confusion or were living with dementia, were sometimes placed on wards which were not equipped to support them. Staff told us this was because beds on general medical wards for elderly patients were full. Placing elderly or confused patients on these wards was a risk because the ward environment and staffing levels were not always appropriate for those patients.
- Beds on the stroke unit were sometimes used for patients who did not have a stroke and should have been placed on other wards. Staff told us this was a problem because there were then no beds available for new stroke patients.
- Data from December 2013, which was given to us by the trust, showed that 69% of patients were admitted directly to an acute stroke unit within four hours of hospital arrival. This was against a local target of 90% and a national average of 58%. (It should be noted, however, the data also showed that 96% of patients spent 90% of their stay on a specialist stroke unit.)

Maintaining flow through the hospital and discharge planning

- The trust took measures to maintain the flow of patients throughout the hospital.
- The trust worked with the clinical site team to develop the trust's escalation plan and staff were able to tell us how the plan worked.

Requires improvement

Medical care (including older people's care)

- Daily board rounds were undertaken during the week with physiotherapists and occupational therapists attending, in order to review patients' progress and expedite discharge planning.
- The trust had implemented admissions avoidance measures, including an emergency ambulatory care pathway.
- There was dedicated pharmacy support on AMU, which helped increase turnaround times for 'to take out' medicines (TTOs) and speed up patient discharge from the hospital. The pharmacy team worked half days at the weekend, providing TTOs, so that patients who needed to take medication home could be discharged over the weekend.
- Discharge planning began at admission and we saw evidence of this in the patients' records that we saw.
- There was a discharge lounge which was used to facilitate patient discharge, but staff told us it was not as well used as it should have been.
- Even though the trust took steps to manage patient flow, we found there remained significant challenges in this area.
- In order to facilitate flow, patients were often transferred between multiple wards within a short period of time, often late at night.
- Many patients were kept on medical wards long after they were assessed as being medically fit for discharge.
- The majority of patients whose discharge were delayed were elderly people who were waiting for a care or nursing home bed or for a care package. Staff told us there was a shortage of care and nursing home beds, which meant patients who needed to be placed in such a home had to stay in hospital until a bed became available. They also said social care packages intended to enable patients to be cared for at home were often delayed, which meant patients had to stay in hospital until the care packages were in place.
- Over 60% of the patient records we looked at were for elderly patients, most of whom were diagnosed as living with dementia. In almost every set of patient records we saw, we found patients had been assessed as medically fit for discharge for at least three days. Discharge planning documentation showed liaison with social services, physiotherapists and occupational therapists, but often noted delays in approving care packages or problems securing care home placements.
- We found problems procuring and supplying compliance aid dispensing boxes for medicines, called Nomad, led to delays in discharging some patients. We were told the compliance aid was provided by a community pharmacist rather than by the hospital's pharmacy team. Ordering a compliance aid involved a complex and time consuming process, and patients who needed them could not be discharged until the compliance aid arrived at their home.
- Some discharges were delayed because of the length of time it took to get electronic discharge letters (EDLs) written. The trust's discharge policy states that EDLs should be completed within 24 hours prior to discharge where possible, in order to prevent delayed discharges. The 24 hour target was not always being met, although staff said this was improving.
- Staff also told us that patient discharges were sometimes delayed because there were long waiting times for percutaneous endoscopic gastrostomy (PEG) feeds.

Meeting the needs of people

- Patient's needs were well met, but there were notable exceptions.
- There was a nurse with overall responsibility for learning disabilities, and staff told us they could contact them if they needed to do so.
- An older person's mental health liaison team provided staff training in dementia care, although most of the staff we spoke with told us they had not attended dementia care training.
- Some staff told us they had completed an internet-based training programme in dementia care.
- Staff told us they did not have training in meeting the needs of challenging or aggressive patients.
- Ward staff across the medical division raised concerns with us about how confused patients and patients with complex needs were distributed across wards. They said patients were allocated from AMU to other wards without regard to the adequacy of the ward environment, availability of equipment, or staffing levels. There was a particular problem affecting patients living with dementia who often needed considerable support from staff and needed to be cared for on a dementia-friendly ward.
- We observed confused patients and patients living with dementia on many of the medical wards we visited, and some of the wards were not appropriate for patients with dementia.

Requires improvement

Medical care (including older people's care)

- During our out-of-hours visits, we observed patients being admitted to wards after midnight. Staff told us that late ward admissions happened most frequently when beds in AMU were under pressure. Patient records showed repeated transfers of confused patients or those living with dementia. In one case, a patient living with dementia was moved from A&E to AMU and then to two subsequent wards in less than 24 hours. Repeated transfers of confused or demented patients often causes them additional stress and anxiety as they are more prone to confusion and disorientation.
- Interpretation services were available, but staff told us they were not widely used. They said they relied on staff or family to translate, where possible. A significant exception was at the Windsor Dialysis Unit. Many of the service's patients did not speak English as a first language. Professional interpreters were booked in advance of patient reviews with consultants.
- Information leaflets explaining different clinical conditions and treatments were available on some wards, but not all. Information leaflets were only available in English and not in other languages.
- There was strong demand for medical beds throughout the hospital, and capacity was stretched.
- In response, the trust designated 18 additional beds, called 'surge beds', on most of the wards we visited, including AMU.
- There were two wards that had been made permanent to increase capacity, called Redlands and Hurley, which staff referred to as escalation wards. We found the facilities and general environment on Redlands needed improvement.
- Much of the equipment on the ward was old and shabby. Staff told us the ward did not have an equipment budget of its own and so had to take or borrow furniture and equipment from other wards across the trust.
- The facilities on Hurley were well adapted to meet the type of patients who were admitted onto the ward. There was a clear effort to make the ward homely, and physiotherapy equipment was available to support rehabilitation patients.
- Two of the wards we visited, Burghfield and Emmer Green, were designated elderly care wards. Both wards were recently refurbished in line with current dementia care standards. We found positive measures were taken to help orient patients, to minimise their confusion, and support them to be as independent as possible.
- On some wards, we found day rooms and shower rooms which had been converted into patient 'surge' beds. These converted rooms were often windowless and located far from a nurse's station. Some were also far from toilet and shower facilities. They were, however, in an adequate state of repair but had handwash sinks and working call bells.
- On AMU, we observed a member of staff helping a female patient to use the toilet whilst the door to the toilet was held open by a wheelchair which was stuck in the middle of the door frame. The toilet was located immediately across from a bay occupied by male patients and the female patient could be seen by others. The wheelchair could not fit into the bathroom as the bathroom was too small to accommodate it. We observed both the staff member and the patient struggling to move in the small space as the patient was assisted into the wheelchair.

Communication with GPs and other departments within the trust

- General Practitioners (GPs) could refer patients directly onto some specialist wards without having to send them through A&E. This included oncology, renal and chest clinic patients.
- GPs could get advice direct from specialities during the working week.
- Doctors we spoke with in the renal department told us that arrangements were in place for communicating with GPs any changes to patients' medicines. However, some of the renal patients we spoke with said their GPs did not receive correspondence about their medicines. They also said there were occasional disputes between GPs and the trust about who was responsible for referring patients to other services for treatment of conditions which were related to their renal failure. These patients felt they were bounced between their GP and the hospital, with each party claiming the other one was responsible for making the referral.

Complaints handling (for this service)

- Many of the patients we spoke with told us they felt comfortable raising concerns with ward staff, and were confident their concerns would be dealt with.
- However, many patients who had already made a complaint to the trust told us they were not happy with

Medical care (including older people's care)

the trust's handling or response to their complaint. A key concern was that the trust did not respond promptly to complaints and did not respond effectively to make improvements to services as a result of complaints.
- Information about the Patient Advice and Liaison Service (PALS), and about how to make a complaint, was available on all the wards we visited and at the Windsor Dialysis Unit.
- Staff told us ward managers investigated complaints and gave them feedback on investigation findings.

Are medical care services well-led?

Requires improvement

There was good leadership on most of the medical wards we visited, except Redlands and Adelaide. There was a strong sense of teamwork amongst staff and a commitment to putting patients' needs first. Staff took clear ownership of the trust's vision and took pride in the patient-focused ethos they felt it represented. Ward staff felt well supported by their managers and told us they could raise concerns with them. However, the visibility of divisional managers and executive leads on medical wards was poor. Staff felt disconnected from the board, and raised concerns about the lack of communication from the trust's senior managers. Medical and nursing staff did not feel their concerns were acknowledged or addressed by management. Staff were open to learning from incidents and complaints, and making changes as a result, although improvements were required in order to ensure the trust was learning effectively from complaints. Innovation was encouraged and there were examples of innovative changes which staff had made in order to improve standards of care.

Leadership of service

- There was good leadership on most of the medical wards we visited, with particularly strong ward management on the coronary care and stroke units.
- Medical leadership on Redlands and Adelaide was poor.
- Ward staff generally felt well supported by their managers and told us they could raise concerns with them.
- Staff across medical wards told us matrons were visible and had a regular presence on their ward.
- With only one exception, junior doctors felt well supported by consultants and senior colleagues. They told us consultants were accessible and approachable.
- However, the visibility of divisional managers and executive leads on medical wards was poor. Staff felt disconnected from the board and raised concerns about the lack of communication from the trust's senior managers. They particularly criticised the way in which the former chief executive's departure was relayed to them.

Culture within the service

- Staff spoke positively about the services they provided for patients. They were proud to work for the trust, and there was a very strong sense of team spirit, both across the trust and on individual wards.
- Staff survey results from the NHS Staff survey showed staff felt well supported by their managers. The trust scored as expected or slightly better for 24 out of the 28 survey indicators.
- Staff were clearly committed to their work and to providing high quality care for patients. We observed many examples of caring and compassionate care, which was provided even when staff were stressed and under pressure.
- At handover meetings, staff were well informed about the patients in their care and showed a genuine interest in the progress and welfare of their patients.
- Quality and patient experience was seen as a priority and everyone's responsibility. Staff told us they were encouraged to report incidents and to make suggestions for improvement.

Vision and strategy for this service

- A copy of the trust's vision was located on a notice board on every medical ward we visited.
- Staff were able to repeat the vision to us at focus groups and during individual conversations.
- Staff took clear ownership in the vision, and took pride in the patient-focused ethos it represented.
- However, staff across the division were unclear about what actions were being taken in response to capacity pressures across the trust.
- They were concerned about how increasing workloads would be managed and how standards of care would be maintained given the high turnover of patients on many medical wards.
- One member of staff, representing the sentiments of a group, commented that bed occupants on any one

medical ward changed before ward rounds could be completed and this meant ward rounds were continually extended to include newly admitted patients.

Governance, risk management and quality measurement

- Most wards had monthly team meetings in which performance issues, concerns, complaints and general communications were discussed.
- Where night staff were unable to attend ward meetings because they were held in the day, steps were taken to communicate key messages to them.
- Staff on some wards told us ward meetings were intermittent, and were sometimes cancelled because of workload.
- Complaints, incidents, audits and quality improvement projects were discussed at monthly speciality clinical governance meetings. These were also reviewed at divisional level.
- A quality dashboard was presented, so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to provide.
- Where performance fell below what was expected, staff were informed and action was taken in response.
- Risks were regularly identified and flagged on risk registers at ward level and at care group and directorate level.

Innovation, learning and improvement

- Innovation was encouraged from all staff members.
- There were examples of innovative changes which staff had made in order to improve standards of care or in attempts to resolve local problems. One good example of this was on the coronary care unit, where staff changed their working patterns to ensure adequately skilled staff were on duty during every shift.
- Staff were open to learning from incidents and complaints, and making changes as a result. They were able to give us examples of changes they had made as a result of incidents and complaints.
- However, a report from the patients association from March 2014 found improvements were needed to the trust's complaints handling system. Key issues highlighted were that patients and relatives were not supported to make complaints; complainants were not informed of changes which were made as a result of their concerns; while a further issue also regarded the lack of timeliness in responding to complaints.

Requires improvement

Surgery

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

Information about the service

The Royal Berkshire Hospital has 18 operating theatres and three recovery areas on the main site. There are eight surgical wards, plus a Day Surgery Unit. Surgery also takes place at the West Berkshire Day Surgery Unit and the Prince Charles Eye Unit. The Prince Charles Eye Unit has two operating theatres and provides eye casualty treatment, which includes a telephone triage service. An out-of-hour's service is operated by the Royal Berkshire Hospital; the West Berkshire Day Surgery Unit has two day case operating theatres, which offer treatments under both general and local anaesthetic.

Summary of findings

Nurse staffing levels were insufficient due to vacancies with a consequent reliance on bank and agency staff. Checking and maintenance of equipment was inconsistent across the service. Capacity pressures across the trust resulted in patients' operations being cancelled or delays in patients being admitted to a ward post-operatively, with some patients being cared for in the recovery area overnight.

The 18 weeks from referral to treatment (RTT) targets were not consistently being met. A variation in practice for pre-operative assessments led to operating lists being changed on the day, or patients' treatments being cancelled. Completion of the WHO surgical checklist was consistently embedded in practice.

Patients were treated with respect, dignity and compassion. Whilst there was positive feedback about managers and matrons, there was a reliance on goodwill and staff felt there was no cohesion over the directorate, as areas worked independently without a clear vision or robust forward planning.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We found that where patients had been identified pre-operatively as requiring an ITU or HDU bed they still continued with the procedure despite knowing a bed was unavailable. We were told that some of these patients were kept in recovery overnight if there was no available bed on the ward. Visiting was limited to times when recovery was quiet, and access to washing facilities and toilets was limited. Staff we spoke with told us this happened on a frequent basis.

We found that maintenance and checking of some equipment at all sites was inconsistent. Most equipment was labelled with a date, but it was unclear whether this date was when the equipment had been checked or was due to be checked. Senior staff we spoke with were unclear about the process for maintaining some equipment and the meaning of the labels.

Staffing arrangements impacted on safety. There were staffing shortages reported on surgical wards and in radiology. These were mainly for registered nurses and healthcare assistants. The director of nursing for planned care told us that the trust had undertaken recruitment drives in Ireland, Scotland and further afield, and further drives were planned. However, they acknowledged that staffing remained one of the biggest challenges they faced.

Cleanliness, infection control and hygiene

- We saw that staff across all three areas wore clean uniforms, with arms bare below the elbow and that personal protective equipment (PPE) was available for use by staff.
- We saw in ward areas, theatres and recovery, separate hand washing basins, hand wash and sanitiser were available. We noted that hand washing technique posters were not available at all sinks to give guidance to staff or relatives visiting the wards. We saw all staff use hand gel appropriately in-between supporting patients.
- We saw that the theatre and recovery areas were clean and well maintained.
- We visited the wards and saw that some wards in the older part of the Royal Berkshire Hospital had visible drill holes in the wall, and some areas were not visibly clean, which was a risk to infection control. Senior staff we spoke with told us there was a significant delay between requesting maintenance work to be done and completion of the work. We were also told there was often a cost implication to the work which made work prohibitive.
- We saw throughout the clinical areas that general and surgical waste bins were covered and the appropriate signage was used.

Nursing Staffing

- On every surgical ward in the Royal Berkshire Hospital we were told that they were below the recommended staffing levels. Staff reported they were regularly understaffed and that the shifts were covered by NHS professionals, an external nursing agency, or that existing ward staff covered the shortfall.
- On Sonning ward there were five registered nurse vacancies. In addition, there were shortfalls in staffing of all grades to ensure that 23 beds could remain open to accommodate overflow surgical capacity from elsewhere within the hospital. The ward regularly relied on temporary staff to meet this shortfall. This affected continuity of patient care. Some staff expressed frustration that although staffing levels were not unsafe, they did not have time to spend any quality time talking to patients, many of whom were anxious or distressed.
- On Hunter and Lister wards, there were ten vacancies (six HCA and four RGN). Senior nursing staff for these wards told us that it was frequently difficult to staff the wards to the optimal levels, even with regular use of temporary staff. They told us that a skill mix review had recently taken place and this had recognised that acuity and complexity of patients required additional staff, which had now been agreed and would be funded from 1 April 2014. On the day of our visit the ward was fully staffed, albeit with two agency staff making up the numbers. Despite this, the ward was very busy and staff were rushed. Two patients complained to us that they had to wait too long when they requested support, although they were not critical of the staff, who appeared to be working very hard.
- The director of operations told us that beds on Hunter ward had been closed recently because staffing levels were insufficient to ensure safety was maintained. We were told that a forthcoming 'super Saturday' was cancelled because staffing levels would not have been safe it went ahead.

- At the Prince Charles Eye Unit we were told that staffing levels were good, but that they experienced difficulties in filling vacancies. We were told there were two registered nurse (RN) vacancies and that bank staff or existing staff were being used to cover the shortfall.
- At West Berkshire Community Hospital we were told that they had a vacancy for one RN. We were told that because of the location of the hospital, recruitment of staff can be difficult. The senior nurse told us they have a very low turnover of staff and existing staff cover any shortfall.

Medical Staffing

- Junior doctors told us that there were adequate numbers of junior staff on the wards and that the consultants were contactable by phone if they required advice or support. Junior doctors told us they felt well supported by their senior colleagues.
- At the Prince Charles Eye Unit medical staff vacancies had impacted on waiting lists.
- The gastrointestinal surgeons provide a 24 hour emergency service, and the on-call gastrointestinal surgeon is free from other duties whilst on-call.
- Junior doctors were part of the 'hospital at night team' that stayed on site for emergencies. We were told they could always contact senior staff for support if required.

Nursing Handover

- We witnessed a ward handover between shifts where incoming staff were updated on each patient's condition. There was a handover sheet which summarised the current situation including diagnosis, problems and any known allergies. This did not consistently contain all relevant information. For example, for one patient who according to staff was confused, frequently walked around the ward and sometimes fell, this information was not recorded. For another patient, it was not recorded that they were living with dementia, and for a third patient it was not recorded that the patient suffered from depression. A staff member assured us that one-to-one handovers between staff ensured that all relevant information was passed on.

Management of the deteriorating patient

- The surgical wards used a recognised early warning tool. There were clear directions for escalation and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at the completed charts and saw that staff had escalated their concerns correctly, and repeat observations were taken within the necessary time. However, we noted on one ward that a patient had scored highly on the early warning score, recorded on the electronic system; however, the recording in the written notes was lower. We spoke about this with the nurse responsible for the patient; the nurse immediately went to check the patient.

World Health Organization Safety Checklist

- Use of the checklist was embedded in surgical practice throughout the directorate at the Royal Berkshire Hospital, West Berkshire Community Hospital and the Prince Charles Eye Unit.
- The Royal Berkshire Hospital monitored compliance with the WHO checklist on a monthly basis. A recent audit conducted in Central and South theatres showed there was 100% compliance, with the exception of documentation regarding the checking of the anaesthesia machine. A plan of action was implemented and a deadline set.
- We were told that no overall audits to check compliance had been conducted at the Prince Charles Eye Unit or West Berkshire Community Hospital.

Safety Thermometer

- Safety thermometer information was clearly displayed at the entrance to most of the wards. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections, and new pressure ulcers.
- 'Champions' had been appointed in each team to focus on safety aspects on the ward; for example, falls and infection control. They attended regular meetings, and provided guidance and support to other team members.
- Risk assessments for the above were being completed appropriately on admission.
- We noted at West Berkshire Community Hospital that there was no visible information regarding safety displayed.
- All areas had their own risk register relevant to perceived or actual risks on the ward. Some senior staff members were unsure what risks had been documented on their register.
- The manager at West Berkshire Community Hospital had designed a clear register to address all the risks in the day surgery area.

Requires improvement

Surgery

Incidents

- The trust reported four 'never events' between December 2012 and January 2014, which had led to a full root cause analysis. We saw evidence that staff had changed their practice accordingly, to ensure the events did not happen again.
- During our inspection we were told about another recent 'never event' at the Prince Charles Eye Unit. The event was currently under investigation.
- All staff we spoke with stated they were encouraged to report incidents, and themes were discussed at ward meetings. Staff gave examples of how their practice had changed as a result of incident reporting. Staff in theatres showed us a resource file which had been developed that contained photographs and information to guide staff to ensure instruments were checked correctly.

Environment and Equipment

- Throughout our visit to all three sites we saw evidence that the information regarding checking and maintenance of equipment was inconsistent. On some equipment we saw clear labels detailing when the equipment was checked and the next date for the next check. On other equipment we saw a small sticker with a date.
- Most staff we spoke with were not sure whether the date represented when the equipment had been checked or when it was due to be checked. Some of the labels displayed a date in 2012.
- The inconsistency of labelling led to confusion about whether the equipment was safe to use, and whether it gave reliable information about the patient's condition.
- One member of staff in the Day Surgery Unit told us they had contacted the clinical engineering department to clarify when the equipment had been checked; they told us that some of the labels on the equipment did not reflect the date when they were checked.
- Concerns were expressed by staff about the condition of premises at the Royal Berkshire Hospital, particularly in the older south block of the hospital. On Hunter ward a senior staff member told us that it was difficult to get basic maintenance undertaken.
- We saw peeling plaster on the walls in a treatment room, and were told this had not been reported. Staff said that when they reported defects such as this, they did not get rectified, so they gave up reporting them.
- A member of staff told us that the design and layout of the ward meant space was limited, with little circulation or storage space. We observed staff having to walk across a patient's crash mat on the floor in order to get to the wash hand basin.
- Toilets were small and made manual handling difficult.
- A staff member told us that, although some patients could be frequently observed, some bays were out of the direct sight of staff, and patients were at risk of falls.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were monitored to ensure that the temperature was kept at a range suitable for some medication. We noted on both Hunter and Lister wards that there were gaps in the recording for fridge temperatures. We were told that the pharmacy technicians monitored these recordings to ensure they were completed. We were unsure whether any action had been taken to address the gaps in temperature records.
- Fridge temperatures were monitored at West Berkshire Community Hospital on a daily basis. We were told that no overall audit is conducted to monitor compliance.

Records

- Records were kept in paper and, in some areas, in electronic format. There were risk assessments undertaken for each patient when they were admitted to the wards, and we saw that these had been undertaken promptly. Care bundles were implemented to alert staff to identified risk, such as the risk of falls or developing pressure ulcers, and provided prompts on the actions to be taken to manage these risks. Different coloured stickers were affixed to patients' records to alert them that care bundles were in place. However, record keeping was poor and we could not be assured that patients were protected from unsafe or inappropriate care and treatment. We saw three examples on Hunter ward where the documentation was inconsistent and did not accurately reflect the regime of care being provided.
- For one patient, who had been identified as being at high risk of developing a pressure ulcer, a pressure ulcer prevention care pathway had been initiated. An air mattress had been provided and a re-positioning regime put in place. However, the documentation did not specify what the regime was, and the records of

re-positioning were inconsistent. We could not be assured that this was happening with the required frequency, and therefore whether the risk of pressure ulcers was being effectively managed.

- One patient had a food and drink chart completed on a daily basis. The forms used to record their intake had been regularly completed, but did not indicate this patient's dietary needs, or whether they needed assistance to eat and drink. We read in their medical notes that this patient required a soft diet and was designated as needing a red tray (this alerted staff to the fact that they needed assistance to eat and drink). The notes indicated that they need prompting to eat and drink, but staff seemed to be unaware of this. This inconsistency of documentation posed the risk that patients were not adequately protected from identified risks.
- We saw that a fluid balance chart had been maintained for another patient, but the reason for its use was not clear and the minimum fluid intake was not specified. The inputs and outputs each day had not been totalled or monitored to ensure the patient was adequately hydrated.
- One patient record we looked at showed that they had a urinary catheter in place. The care bundle required that the doctor should review the need for the catheter on a daily basis unless it was specified for long-term use. There was no indication as to whether the patient had a long-term need or that the need had been reviewed.
- We found West Berkshire Community Hospital and at the Prince Charles Eye Unit contained sufficient information in the records to staff to enable them to care for people effectively.
- Staff at West Berkshire Community Hospital told us that they spent a large proportion of their time looking for notes. They told us that the electronic system was designed to order notes automatically; however, this had stopped happening. They had raised this issue, but it had not been addressed. As a consequence, they had to manually order notes from the main hospital a week in advance. They told us that they check daily to monitor that the notes had arrived.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately and correctly. Patients we spoke with across all three sites told us that staff had explained everything prior to their operations, and that they had been encouraged to ask questions throughout the process.
- Staff were able to access safeguarding training. However, during our conversations with a senior member of staff, we were told that knowledge was inconsistent in relation to safeguarding across the trust.

Pre-operative Assessment

- Pre-operative assessment is conducted for some surgical specialities in the south block annexe (which is a portakabin in the south block car park). We were told that patients were ideally seen about four weeks prior to routine surgery, but staff shortages meant that this could be variable, and on occasions assessments were too close to the operation to prevent cancellations.
- Consent was taken variably either in the clinic at the time of listing, pre-operatively in consent clinics, or prior to surgery on the day. Staff we spoke with told us that because of this variation in practice for assessment and consent, operating lists were commonly altered due to the anaesthetist or surgeon changing their mind on the day of operation. The alteration of operating lists would need to be communicated to the theatre staff and ward staff to ensure that both equipment and beds were available.
- Staff told us that the timings of pre-operative assessments needed to be co-ordinated.
- Patients told us that the pre-operative assessment unit was difficult to find, and if they needed further tests they were required to go back into the main hospital, which some people with mobility needs found difficult. The Chesterman Unit was cramped. Patients told us that they found the unit confusing to find and there was "a lot of traffic", which was not a calming atmosphere to be in prior to an operation.

Mandatory Training

- The Trust has a target of ensuring that 85% of staff have completed their Mandatory Training. Although improving, the trust are not meeting the target. Examples within Surgery included 84% of staff have

attended infection control training and 74% of staff have attended Safeguarding Adults training. They were implementing a number of initiatives to ensure that this remains an improvement priority.
- Staff told us that due to staff shortages in some areas, they had to cancel their attendance on training days to meet staffing levels on the wards.

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

Good

The use of national guidelines and the enhanced recovery programme was used, where relevant. There was evidence of comprehensive audit programme to monitor the quality of care. There was a performance dashboard to monitor quality.

Multidisciplinary team working was in place with physiotherapists and occupational therapists support accessible. Surgical wards had a daily visit from a pharmacist and antibiotic use was monitored by the microbiology department. Delays in Cardiology review was a concern among staff and impacted on the flow of patients.

Patients felt access to pain relief was effective and in a timely manner. There was a consultant led seven day on call service and on call pharmacy provision at all times.

Use of National Guidelines
- The enhanced recovery programme is utilised in all specialities where it is relevant.
- Emergency surgery is managed in accordance with National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommendations.
- Surgery out of hours is consultant-led and delivered.
- Regular meetings were held to discuss changes to guidance and the impact it would have on their practice.
- The trust provided us with a list of completed and on-going clinical audits to ensure the quality of care was monitored.

Outcomes for Surgery
- The directorate contributes to most of the national audits for which it is eligible, including the Trauma Audit and Research Network.
- The directorate had a performance dashboard that it used to monitor the quality of care they provided.
- Staff spoke to us about their concerns regarding administration errors. Senior managers acknowledged that this was a trust-wide issue and was particularly acute in ophthalmology. They told us that approximately 15% of appointments were rescheduled.

Care Plans and Pathway
- Enhanced recovery pathways were used.
- Nursing documentation was either kept at the end of the bed, or recorded on an electronic system.

Multidisciplinary Team working and working with others
- Patients had support from physiotherapists and occupational therapists if required.
- An elderly care consultant was assigned to the Trauma and Orthopaedic wards, and conducted a daily ward round.
- Daily morning trauma meetings took place in theatres to assess patient's injuries and the order in which operations took place during the day.
- Each ward at the Royal Berkshire Hospital had a daily visit from a pharmacist, and antibiotic prescribing was monitored by the microbiology department. Staff at West Berkshire Community Hospital told us there was no overall monitoring of their antibiotic prescribing conducted by the trust.
- Staff at West Berkshire Community Hospital told us they had access to a physiotherapist for patients undergoing certain types of hand surgery. They did not have dedicated physiotherapy support for other patients. If they required further advice, they contacted other areas of the hospital for physiotherapy support.
- We were told that it was difficult to contact specialist cardiology support for patients on the surgical ward, which consequently impacted on the flow of surgical patients. Staff on the ward told us they referred patients by fax and daily phone calls, and it could take up to a week before patients were seen.

Equipment and facilities
- There was appropriate equipment available to ensure that effective care could be delivered.

Requires improvement

Surgery

- The staff at West Berkshire Community Hospital told us that they have plenty of equipment, some of which had been supplied by charitable funds. There are plans to extend the ward area later this year, to enable them to offer single sex accommodation for patients.

Pain relief

- People were prescribed regular pain relief. Patients told us that staff conducted regular rounds to see if they were comfortable. Patients were regularly asked about their pain levels, particularly immediately following surgery. This was recorded in a pain assessment tool. Most of the patients we spoke with at the Royal Berkshire Hospital told us they were given their medication in a timely fashion. Two people told us they had to ask several times for their pain relief. They told us they thought this was because the nurses were "rushed off their feet".
- Patients at West Berkshire Community Hospital commonly had their operations under an anaesthetic block or local anaesthetic, which meant that they stayed awake during the procedure. Patients we spoke with told us they felt no discomfort, and were advised to take pain relief at home when the anaesthetic wore off.

Seven day services

- At the Royal Berkshire Hospital there was a consultant-led on-call service, during which time the consultant would not have any other duties.
- The Pharmacy was open 9am–1pm Saturday and 10am–1pm Sunday. They had TTO (to take out) packs of commonly-used medicines in A&E and ECU. They also had in place the use of FP10 prescription forms, to get supplies from outside chemists if needed, when the pharmacy was not open.
- There was an on-call service for pharmacy. Staff told us that the service worked very well and they were able to obtain the medication they required out of hours.
- There was an emergency drugs cupboard on site. The site manager held the keys, and staff told us they would contact the manager to obtain extra medication if required.

Are surgery services caring?

Good

Whilst some patients and their families gave examples of care which lacked compassion, other patients and their families that we spoke with were positive about the care they received at the Royal Berkshire Hospital and at the Prince Charles Eye Unit. People described staff on the wards as "lovely" and "very caring". Everyone told us that the nurses on the wards were extremely busy and worked very hard. Patients noticed that some areas were understaffed, and did not wish to make any complaints about the nurses.

During our observations at the Royal Berkshire Hospital we saw that staff treated people with respect, and that curtains were closed, to protect people's dignity, when personal care was being delivered. We noted that staff appeared to be very busy and were unable to spend significant time talking with people.

People spoke positively about the pre-assessment unit. They told us they were given enough information to help them make decisions about their care, and the nurses explained everything to them. People told us the service was "excellent" and their only concerns were about the unit being housed in a temporary portakabin in the grounds of the hospital, which was difficult to find.

At the West Berkshire Community Hospital, we observed a relaxed atmosphere, and time was spent with patients to reassure them prior to their operations. Staff appeared to be happy and motivated in their work and all of the staff we spoke with told us they enjoyed working at the hospital. Patients spoke very positively about their experience and described the staff as "fantastic".

Compassionate Care and emotional support

- The Friends and Family Test results for surgery showed that three surgical wards (Sonning, Kennet and Hopkins) had a low response rate to the survey. Sonning ward was one surgical ward that two people would be 'extremely unlikely to recommend'; however the majority stated they would be extremely likely (17 people) or likely (5 people) to recommend the surgical wards.

Requires improvement

Surgery

- The cancer patient experience survey showed that with regards to surgery, the trust performed better than other trusts with reference to patients being given written information about operations, and receiving clear information about what people could and could not do post-discharge from hospital. Areas where the trust performed worse than other trusts concerned staff giving a complete explanation about the purpose of tests, and definitely involving patients in decisions about care and treatment.
- The hospital regularly captured feedback using the Friends and Family Test. Monthly results were displayed on notice boards entitled 'You said, we did'. This highlighted areas that people had commented on for improvement and detailed how the ward had responded. The trust also captures feedback via a monthly in house inpatient survey.
- The West Berkshire Community Hospital did not conduct any formal feedback surveys.
- The Prince Charles Eye Unit used a token system to enable people to give feedback on the service. People inserted tokens into different slots to indicate their level of satisfaction. There were also comment cards for people to use. As a result of some recent feedback, the department was in the process of colour coding areas to make navigation around the unit easier.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Patients told us “they always treat me with respect and they asked what name I like to be called by”. Another patient told us “the nurses are so kind; nothing is too much trouble for them”.
- Staff told us that at times they felt too busy to be able to spend much time with patients to offer emotional support.
- Call bells were answered promptly and one patient told us “they always come very quickly when I ring the bell”. Another patient told us “sometimes there are delays in answering the bell when the staff were very busy”.
- We watched a ward round and saw that the doctors introduced themselves and took time to explain what they were going to do. Curtains were drawn round people appropriately, to maintain the dignity of people they were examining.
- Records contained information about discussions held with patients and relatives. On the whole, these were recorded sensitively; however, we saw in one record, evidence of poor communication between staff and relatives, which had led to confusion.
- Senior staff on the wards told us that visiting hours were flexible, especially when patients were unwell.
- We observed an anaesthetist in discussion with a patient in the area. The conversation could be heard by other patients and confidentiality was not maintained. Relatives and patients expressed their concerns regarding this, with us during our observation.

Patient Involvement in Care

- Patients and relatives we spoke with at the Royal Berkshire Hospital stated that they felt involved in their care. They told us they knew who their consultant was and they felt able to ask questions if they needed to. One relative told us “we know exactly what is going on, and if we need more information we only have to ask”.
- Patients undergoing eye surgery at the Prince Charles Eye Unit told us they were well informed about their eye conditions and their treatment. They said that nursing and medical staff had explained everything to them in a way that they could understand, and they understood the risks and benefits of treatment.
- At the West Berkshire Community Hospital patients told us they had received sufficient information, and communication was very good. One patient told us “I am quite amazed at the whole process, it’s really very good and the staff are brilliant”.

Are surgery services responsive to people’s needs?

(for example, to feedback?)

Requires improvement

There were a large number of medical outliers on surgical wards, which impacted on the surgical wards ability to accommodate patients in their speciality.

We discussed our concerns about capacity and outliers with the senior managers. They acknowledged there was “not enough surgical capacity”. There were a number of 'surge beds' which were provided to create additional

capacity when demand outstripped available capacity. Hopkins and Dorrell wards had such beds, which could accommodate medical outliers and were supported by allocated physicians.

The recovery area was used for patients overnight. Staff told us that in recent months this had become a regular event and happened up to four times a week in some weeks. We were told that if recovery was full, the emergency theatre would stop operating, and staff from theatre would be required to support the recovery staff until patients were stable, or had been discharged.

At the Prince Charles Eye Unit staff told us that they were currently performing only 16 out of a possible 20 operating lists per week, due to a shortage of staff. Consequently, a significant number of people were waiting over 18 weeks for their operations.

Overall, the referral to treatment figures showed that between August 2013 and January 2014 87% of patients were treated within 18 weeks (in January 2014 it was 82%).

The director of operations told us that there was a significant problem with radiology capacity, and scans were being outsourced to private providers to address this.

Patients showed us information that had been given to them about their operations, which contained detailed, personalised instructions regarding when to stop taking medication, and what time to stop eating and drinking.

Access

- The trusts average for bed occupancy between October–December 2013 was 89%, compared to the England average of 86%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- 90% of patients with a fractured neck of femur were treated within 48 hours. The National Hip Fracture Database report for 2013 stated that the average treatment time across the 186 eligible hospitals in the UK was 86%
- Within general surgery, the cancer two week wait target was 93% which they were currently meeting. The two week wait for breast symptoms set by the trust was 93% and they were currently exceeding that target at 95%.
- The percentage of surgical specialities that are meeting the referral to treatment times of 18 weeks varied; the highest being Urology at 99% and the lowest being Ophthalmology at 87%, over the period of August 2013 to January 2014.
- Overall, the referral to treatment figures showed that between August 2013 and January 2014 87% of patients were treated within 18 weeks. In January 2014 only 82% of patients were treated within this timescale.
- There was a separate team for emergency theatre, and there were agreed protocols to defer elective activity, in order to give adequate priority to unscheduled admissions.
- Between January 2013 and December 2013 the Royal Berkshire Hospital performed 23,739 elective operations. Cancellations the day before surgery totalled 529 patients, which was 2% of all patients.
- The most recent data received from the trust for February 2014 showed that 1,856 patients were treated, with 130 cancellations, which equalled 7.0% of all patient operations. 18% of the patients cancelled on the day were due to theatres or equipment failure. We also saw that some patient operations were cancelled due to bed capacity issues, administration errors, and staffing. Some patient operations were cancelled because the patients were unwell on the day, or the operation was no longer required. The West Berkshire Community Hospital performed 3,651 operations from April 2103 to March 2014. They cancelled 266 people during that time. Staff told us that the reasons for cancelling were usually due to the person being unfit for surgery on the day, patients not following starving instructions, or not having anyone to take them home and look after them after the operation.
- A senior manager told us that on occasions operations were cancelled because of lack of beds and/or staff. They said that sometimes cancellations were at short notice, and recognised that this caused distress and inconvenience to patients. The hospital sometimes arranged planned surgery at the weekend, in order to address backlogs and maintain waiting list targets.
- A senior manager for planned care acknowledged that the condition of premises in the older south block was “challenging". They reported that a leaking roof in the theatres had recently resulted in closure and cancellation of operating lists.

Requires improvement

Surgery

Maintaining flow through the hospital and discharge planning

- Clinical nurse specialists in emergency surgery were employed to assess patients who were admitted via A&E, and were surgical co-ordinators across the hospital. Their role followed the emergency surgical pathway, which meant they assessed patients in A&E and were able to refer them for further tests if required. In addition, they supported nurses on the wards, and they attended the post-take and other ward rounds. Currently they provide a five day a week service, but are training two further members of staff to be able to offer a service seven days a week.
- Daily board rounds were undertaken five days a week on all surgical wards; physiotherapists, occupational therapists, nursing staff and discharge co-ordinators attended.
- 12 beds from the surgical speciality had recently been lost to critical care (to allow 8 extra beds for critical care). This impacted on patients potentially having to spend longer in recovery to wait for a bed to become available, or be placed on a ward that was not appropriate to their operation. At times, patients were required to stay overnight in recovery because no bed was available on the ward. We saw that between August 2013 and February 2014, between 25 and 30 people had been kept in Recovery overnight each month, with the exception of November when eight people had been kept overnight. These figures represent a mixture of patients waiting for beds to become available on the ward and in ITU.
- The bed manager and staff met during the day, to discuss how many beds were available, or were planned to become available during the day. Staff told us that if patients are admitted through the admission unit prior to their operation, they were able to liaise with ward staff, with regards to availability of beds. They told us that Lister ward was a designated MRSA-free ward, which meant that they could only take patients who had been through the pre-operation assessment process. We were told that staff tried to place people on the most appropriate ward for their operation, but sometimes this was not possible.
- Senior staff on Sonning ward told us that they were originally a gynaecology and breast surgery ward. Due to bed shortages, the ward was now frequently occupied by general surgery or trauma patients. This sometimes presented difficulties in accommodating emergency gynaecology patients on the right ward (two beds were supposed to be protected for gynaecological emergencies, such as presenting with an ectopic pregnancy).
- Staff stated that planning was difficult because of the number of medical outliers on the surgical ward. This affected capacity to accommodate planned surgical admissions. Staff told us this was compounded by the delay in review of medical patients on the surgical ward by the appropriate medical team.
- Staff told us that, at times, they received elderly surgical or trauma patients who were living with dementia, and they found it challenging to care for these patients, in terms of staffing levels, ward layout and staff knowledge of caring for patients living with dementia. Although the trust did provide dementia care training, staff stated they were unaware of this.
- Staff on Sonning ward had undergone further training to enable them to support the needs of patients from other surgical specialities, but had not for medical patients.
- Staff on Hopkins ward told us “there are always escalation beds open on the ward because of the pressures from A&E”. During our visit there were three escalation beds being used by patients.
- Every ward had a discharge co-ordinator, and discharge planning was commenced as soon as patients were admitted to the ward.
- The chief pharmacist told us that the trust target for turnaround of TTOs was 120 minutes, and that 71% of prescriptions hit this target. Staff told us that there was a delay in discharging patients because of delay in TTOs.
- They told us that they were able to track the progress of the prescription electronically, but there were times when patients could be waiting for up to four hours or more for their medication.
- A senior manager for planned care confirmed delay in discharge due to TTO’s was a trust-wide issue and they had identified that part of the delay was caused by doctors not prescribing in a timely manner.
- Weekly MDT meetings were held which social workers would attend.
- A discharge lounge was available for use by patients waiting to go home. Patients could wait in the lounge whilst take home medicines were being dispensed, or transportation home was arranged.

Requires improvement

Surgery

Meeting the needs of people

- Support was available for patients living with dementia and learning disabilities through the hospital's dementia and learning disability champion. All staff we talked with spoke positively about the service offered. Staff stated that the person was supportive, and easily contactable for advice or guidance. The older person's mental health team and the learning disabilities co-ordinator also provided support.
- A translation telephone service was available for people for whom English was not their first language. Staff told us that if necessary they could call on other members of staff to help translate if required.
- There were multiple information leaflets available throughout the hospital, and at the Prince Charles Eye Unit and the West Berkshire Community Hospital. All of the leaflets we saw were in English. Staff told us that leaflets in other languages could be requested if required, but were not automatically displayed throughout the hospital.
- The staff at West Berkshire Hospital told us that they were able to use a local service to assist people who were hearing impaired.
- The ward at West Berkshire Community Hospital was not single sex. Staff told us that there were plans to develop the ward later this year to offer single sex accommodation. They told us they explain the mixed-sex nature of the ward area to patients; if patients prefer, they are offered a side room in which to recover. The patients we spoke with confirmed that this had been explained to them prior to their operation. Bathrooms were designated for single sex use.
- On Sonning ward there was a room which was used for meetings with patients and relatives in private, particularly when sensitive news was given. The room was sparsely furnished and felt cold, clinical and unwelcoming.

Communication with GPs and other departments within the trust

- A discharge summary is sent to the GP by email automatically on patient discharge from the unit. This detailed the reason for admission, and any investigation results and treatment undertaken.

Complaints handling (for this service)

- If a patient or relative wanted to make an informal complaint they would speak to the shift co-ordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. We saw information about how to make a complaint displayed during our visits to all three sites. These were displayed in English.
- Staff told us that complaints were investigated by the senior member of staff for the department concerned. Information about complaints was discussed during ward meetings.
- Staff on Sonning ward told us about a presentation that was given to staff during the regular ward meeting, to address the common complaints received by the ward. Staff received further training to address some of the areas that had caused concern; for example, issues with pain management.
- During our listening event some people told us that they had found that the process of making a complaint took a long time, and that they felt they were not listened to and the trust did not respond to them appropriately.

Are surgery services well-led?

Requires improvement

The leadership of the surgical care group needed to be improved. There was no consistent forward planning, or measurement of the impact that the lack of beds had on either patients or staff. There was no clear vision for the service as staff felt they operated on a 'day to day' basis with significant goodwill from staff. Although staff felt well supported by their immediate line managers and matrons, there appeared to be no cohesion over the directorate. Staff felt they worked independently of each other across the speciality. Some of the senior staff we spoke with, on some wards were unsure about what was recorded on their risk register.

Staff at the Prince Charles Eye Unit told us they felt isolated from the trust, and staff at the West Berkshire Community Hospital told us "the trust don't really know what we do". They told us they felt they functioned well, but independently from the main hospital.

Leadership of service

- Each of the surgical specialities had a clinical lead as well as a directorate lead.

Requires improvement

Surgery

- We spoke with the directors in planned care during our visit. They stated there "was not enough surgical capacity" and the impact of this was that patients would be wrongly located, or planned surgery would be cancelled. There was no clear plan for addressing the immediate situation or analysis of whether the lack of surgical capacity was purely due to the impact of medical outliers or whether there was an actual lack of surgical capacity.
- The directors told us that surgical outliers were monitored on a day-to-day basis at the site meetings, but there was no information available to measure this impact of this aspect of performance on an ongoing basis.
- Staff spoke very positively about one matron who provided visible leadership throughout their speciality. They had made improvements to positively enhance the experience for patients, and as a result of the cancer patient survey, bought quieter trolleys and addressed staff about the issue of noise.
- All staff we spoke with across the three sites told us that they felt well supported by their immediate managers.

Culture within the service

- Staff at West Berkshire Community Hospital spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility. They told us they felt well supported by their manager, who was based at the Royal Berkshire Hospital. However, they also expressed that they felt separate from the main hospital site.
- Staff at the Royal Berkshire Hospital spoke about the difficulties of providing a service when there was a shortage of nurses. It was apparent that the teams worked well together, and there was a lot of goodwill between staff, which enabled the wards to be staffed adequately. Nurses often worked overtime or beyond the end of their shift to ensure their teams were supported.
- Throughout our inspection we noted that all the ward staff endeavoured to "pull together" to ensure patients were supported. They told us they knew about issues within their own surgical speciality, but were not sure about the hospital overall.
- On Sonning ward a staff member proudly showed us certificates displayed on the walls, in recognition of achieving 100 days free from pressure ulcers and C. difficile. They told us that senior managers had visited the ward to present the certificates and had given the staff sweets.
- At the Prince Charles Eye Unit the sister showed vision and passion for the service. They felt well supported by the matron for the service. However, there was also a sense that they felt isolated and powerless to make change. This was partly due to the fact that the assistant service manager position had been vacant for approximately two years.
- The directors were aware that there had been a problem with bullying and intimidating behaviour from senior medical staff in ophthalmology, and this was currently being investigated.

Vision and strategy for this service

- Staff we spoke with at the Royal Berkshire Hospital told us that they felt a pressure to ensure that no operations were cancelled because of bed shortages. Staff told us that they felt they went from "day-to-day" and were unaware of an overall vision for the service.
- They were unable to describe any clear vision for the trust, but felt that everyone had a commitment to deliver the best care possible.
- One consultant we spoke with told us that the trust had a commitment to the continuous improvement of outcomes for patients.

Governance and measurement of quality

- Governance meetings were held within the directorate for each surgical speciality.
- Complaints, incidents, audits and quality improvement projects were discussed.
- Staff at the Prince Charles Eye Unit told us there were regular ophthalmology governance meetings, but they did not feel these were effective and they were not structured in the standardised format required by the trust. They were unsure of the reporting lines and decision-making process above this. For example, we asked them if the issues around administration were on their risk register, and they did not know. A director was also unable to tell us.
- The directors told us that they did not scrutinise the minutes of departmental governance meetings.

Requires improvement

Intensive/critical care

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

Information about the service

The Royal Berkshire Intensive Care Unit (ICU) is located in the south block of the hospital. It is led by a clinical lead, a matron and operationally-led by a lead nurse. The main ICU area had nine level 3 beds, with a further eight level 2 beds in two bays on Heygroves ward. These level 2 beds had the flexibility to escalate to four level 3 beds if the activity necessitated. The ICU area admitted 758 patients in 2012/13.

Critical care also provided outreach to the wards, an outpatient follow up service for patients, and a bereavement and memorial service for families, whilst a research team was also allocated within the unit. The outreach team is led by a nurse consultant and supported by eight clinical nurse specialists who provide a 24/7 service.

The existing ICU infrastructure did not meet with the Hospital Build Notes HBN04-02 guidance or the 'Core Standards for Intensive Care Units'. The ICU had limited ability to isolate infected patients and no ability to reverse barrier nurse immunocompromised patients.

A draft business plan had been prepared to redevelop the Urgent Care Floor, with a recommendation of a 26 bedded ICU.

The current provision does not meet national core standards for medical, technical support, nutrition, rehabilitation, and speech and language therapy. The pharmacy provision is 0.6 WTE pharmacist available over five days.

Summary of findings

Medical staffing levels were not sufficient to meet the needs of ICU and HDU, in particular when HDU had ventilated patients due to capacity pressures in ICU. In addition these pressures resulted in patients being cared for in recovery.

The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme, and outcomes were within expectations for the size of the unit. Staffing pressures prevented proactive review of performance data.

Feedback from patients and relatives was overwhelmingly positive with excellent caring interventions with patients and families always being involved and informed of care. The bereavement service was well established and there were twice yearly memorial services in memory of patients.

Requires improvement

Intensive/critical care

Are intensive/critical services safe?

Requires improvement

Despite an excellent and highly motivated team, the pattern of work and infrastructure is extremely challenging and it will be difficult to sustain long-term delivery of safe quality care due to staff shortages.

There was evidence of elective surgery patients not being admitted to the ICU due to lack of bed capacity and insufficient nurses on duty to enable the patients to be safely cared for. Within the last six months some patients requiring critical care have been cared for post-operatively in the theatre recovery area, and at times, there were insufficient ICU staff to care for these patients appropriately.

We were told by staff that there had been 16 level 3 patients being cared for in ICU the week before our visit. This means that the Heygroves beds had been used to support seven level 3 patients; this is over their defined escalation bed capacity within these bays. The beds on Heygroves ward are geographically-separate location to the main ICU area. Both ICU areas are managed by one clinical team.

In addition, the unit had paediatric emergencies admitted to the adult ICU for stabilisation prior to transfer to the regional paediatric intensive care unit.

Cleanliness, infection control and hygiene

- The unit appeared clean, and we saw staff regularly wash their hands and use hand gel between treating patients. The unit achieved 95% for hand hygiene in February 2014.
- We saw that the ward and department staff wore clean uniforms, with arms bare below the elbow (BBE), and that personal protective equipment (PPE) was available for use by staff. Administration staff were not always BBE.
- We observed a member of staff changing dirty bed linen without the use of PPE's; no gloves or an apron were worn.
- Staff we spoke with were able to describe good infection control and hygiene practices, before, during and after patient contacts. This demonstrated that clinical staff were able to practice good standards of hygiene.
- We saw that general and clinical waste bins were covered, and that appropriate signage was used.
- Intensive Care National Audit and Research Centre (ICNARC) data demonstrated that the unit-acquired MRSA rates were low and similar to other ICU.
- Clinical support workers cleaned the unit and filled in cleaning schedules on a daily or weekly basis, for completed cleaning routines.
- A microbiologist visited the unit to discuss and review all patients. Their role was to advise the ICU team on appropriate treatment of infections and infection control.
- The unit had a nurse champion for infection control.
- Bed spaces, and those in Heygroves bays, were small to deliver safe ICU care.
- The existing ICU infrastructure did not meet with the Hospital Build Notes HBN04-02 guidance or the 'Core Standards for Intensive Care Units'. The ICU had limited ability to isolate infected patients and no ability to reverse barrier nurse immunocompromised patients.

Nursing Staffing

- The unit had a series of shift patterns which were: an early 7.15am– 3.05pm, a late 12.25pm– 8.15pm, night 8pm-7.30am and long days 7.15am-8.15pm. Staffing levels were set to 14, which was increased by booking temporary staff to meet dependency needs of patients as required.
- All level 3 patients were nursed one-to-one, and all level 2 patients one-to-two. Staff reported that they used external agency staff, as well as their own bank staff, to meet staffing gaps. During the period 1 March to 24 March 2014, we saw that 47 agency staff had been used to assist in covering shifts. It was not monitored whether this met the Intensive Care Society (ICS) standards of no more than 20% staff as agency for any particular shift.
- We saw evidence of the nursing rota that confirmed the management of dependencies, staffing requirements and how bank or agency staff had been approved. The unit uses an electronic system, NHSP (NHS Professionals), and any cover requirements are also listed on the daily sheets; these are used by management to authorise agency cover if required.
- There is a practice educator for three days a week working with the ICU team.

Requires improvement

Intensive/critical care

Medical Staffing

- The geographic separation of critical care beds, the number of admissions, the number of level 3 patients, demands for ICU beds and intensity of work meant that recommendations for consultant oversight of the unit made in the Core Standards were not met.
- The consultants were scheduled to be on call for 24 hour periods. Overnight they should be on call from home, but all of the above meant that in reality they were more often than not required to be on site.
- The following morning they would stay until 1300 (working with that day consultant on call) when the morning ward rounds were completed. The on call consultant for that day would then be solely responsible for the 17 patients across the two units until the following morning.
- The Core Standards recommend that there should be one junior doctor per eight patients on the unit which the trust is compliant during the day. However overnight there is only one doctor covering all 17 patients. This contributes to the consultants on-call needing to provide initial support on site overnight.
- All potential admissions to the unit had to be discussed with the duty ICU consultant, and all new ICU patients were reviewed by a consultant soon after admission.
- There had been no increase in the number of medical staff (consultants or juniors) when the number of critical care beds increased from 9 to 17 at the end of 2013.

Management of the deteriorating patient

- There was a critical care outreach team who were present on site 24 hours a day, seven days a week. The service could be contacted by any member of staff, and their contact details were readily available. The team comprised of nurses who had extensive skills and knowledge in recognising a deteriorating patient. They reviewed patients on the general wards in response to referrals from either ward nurses or medical staff, and advised and provided help in the care of patients who may need a higher level of observations or intervention. The outreach team worked closely with all staff from the ICU areas. The team helped to facilitate the transfer of patients from the general wards to ICU and back again.
- The outreach team also had a system that enabled patients and relatives to directly access the critical care outreach team if they had any concerns about the patient's condition that they felt were not being acknowledged by the ward team; this service is called Call 4 Concern (C4C) and is a telephone help line service.
- To ensure the safety of paediatric emergencies, the ICU team had developed a risk assessment and protocol to manage the admission if the event arose, to ensure that the unit provided for a paediatric patient to be cared for until the appropriate children transfer service could respond.

Nursing and Medical Handover within the unit

- We observed both medical, nursing handovers and the ward rounds.
- There is a nursing handover book on the unit, which was completed by the nurse in charge on each shift.
- A multidisciplinary ward round is held from approximately 8am-12 noon, where the doctors and nurses discuss the patients' progress and care, examine the patients, decide on further treatment and make a plan for the rest of the day. This ward round included input from other specialists. There is also an evening ward round from approximately 5-7pm. The handover was structured, documented, and attendance was recorded.

Safety Thermometer

- Safety thermometer information was clearly displayed at the entrance to the unit. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections, and new pressure ulcers. The trust was performing within expected levels for these measures.
- Risk assessments were being completed appropriately on admission.

Incidents

- There have been no recent 'never events' attributed to the unit.
- The lead nurse for the unit was able to describe effective and regular systems in place for reporting of complaints and incidents. They explained how a recent concern from a patient had influenced a change within their transfer process; this showed that staff were learning from incidents and complaints, to improve practice.
- All staff we spoke to stated that they were encouraged to report incidents. As part of the inspection we reviewed minutes of staff meetings held on the unit, and could see evidence of incident reporting and the process

being addressed; in particular about concerns with regards to agency staff performance, and how an incident report should be completed if there were particular concerns.
- We reviewed the ICU KPI report for 2013/14; the report monitored incidents on a monthly basis for infection control, hand hygiene, 'bare below the elbow', falls, pressure sores, nursing drug errors, nursing complaints and Patient Liaison Service feedback. The report was supported by an action plan to address concerns, and make improvements to minimise future risks. Actions and responsibilities of staff were clearly outlined with target dates for completion.
- We reviewed minutes of the ICU Clinical Governance meetings, and noted that incident reporting is on the agenda. This had the incidents listed, with actions outlined to prevent and minimise future risks associated with the incident.

Environment and Equipment

- The environment was safe; trust access control systems were in place at the entrance to the unit.
- Equipment was checked and cleaned daily, but there were no records maintained by the technician on the duties they had completed each day. The lead nurse was aware that the daily logs had not been completed since December 2013 due to resource issues. This was on the risk register due to the limited training for the staff and staff resources.
- Dedicated and standard central line packs are in place.
- There was a lack of individual training records for staff equipment training; it was unclear what training had been completed, if any.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- We observed the process on the unit for the management of controlled drugs, and found it to be meeting the appropriate requirements.
- The unit had the support from a 0.6 wte pharmacist.

Records

- The unit used an electronic patient record system, which we reviewed as part of the inspection process.
- Observation equipment automatically fed into the monitoring system, which had VDU screens displayed within the nurse's station for each of the beds within the nine bedded ICU area.
- Each patient had hospital records which were in a paper format; these were stored on the nursing station. When a patient transferred to a ward from ICU, the ICU staff printed out any appropriate documentation and observations from their electronic system to place in the paper record.
- The ward rounds included a review of the electronic patient record.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately in accordance with the trusts policy. We saw examples of patients who did not have capacity to consent to their procedure; in these circumstances, a multidisciplinary team (MDT), which included doctors, nurses, physiotherapists and a pharmacist, carried ut daily reviews ofthe decisions made regarding treatment in the patient's best interest. The ICU team also have input from a nutritional and a microbiology team. Additional MDT meetings, with the support of specialist teams, are called if the patient has particularly complex care needs.
- Staff we spoke with were not able to explain Deprivation of Liberties (DOLs), but they had an understanding of safeguarding and how to raise a concern to their line manager.

Mandatory Training

- We looked at the trust's mandatory training matrix; attendance for mandatory training in ICU was below the trusts targets in some areas, including safeguarding adults and children, moving and handling, equipment training, information governance and fire safety. The records confirmed that the trusts' induction and other professional role inductions had been completed, along with other core mandatory training, achieving 90% plus for completion by staff.
- There is no local training matrix in place for the unit.

Requires improvement

Intensive/critical care

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

Good

The ICU contributed towards the Intensive Care National Audit and Research Centre Case Mix Programme, and receives regular benchmarking and quality reports. The report showed that ICU outcomes are within the acceptable range. Athough, the unit does not have an action plan based on these reports to drive quality improvements.

Use of National Guidelines

- The critical care unit used NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided. Local policies were written in line with this guidance, and were available on the trust's intranet, and also within the electronic patient system used in the ICU. We found that some of the trust policies had not been reviewed or updated within the review period stated on the policy.
- At the monthly unit meetings any changes to guidance, and the impact that it would have on practice, were discussed.

Outcomes for the unit

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme.
- ICNARC data was not used to drive performance and quality monitoring of the service. A senior nurse confirmed they did not receive a copy of the report and consequently did not have an action plan.
- The ICNARC data showed the length of the stay for all admissions to the unit compares favourably with the national average (RBH 4.2 days for the period 01/07/2013 to 30/09/2013, compared with England average of 4.7 days)
- The lead nurse had an action plan and business case to support meeting the core standards, and although the electronic patient system had the facility to produce performance monitoring reports to assist with audits and drive improvements, this was not currently being utilised.
- Consultants told us that they did not have the capacity to review performance data due to lack of time and resources.

Care Plans and Pathway

- The unit used the patient electronic system during the daily ward round; this was completed during the morning ward round. Clear objective outcomes were identified and documented.
- Nursing documentation was recorded on the patient electronic system. This was not recorded in real time due to resourcing issues. We observed that nurses had pieces of paper in their uniform pockets with observations written on them; because of the time constraints, they could not always access the computer immediately to update the patient records.
- Care bundles were recorded within the electronic patient system, but it was not used to drive improvements.

Consultant Input

- Consultants undertook ward rounds twice daily. They were present on the unit during the day, and often out of hours.
- All potential admissions had to be discussed with a consultant, and all new admissions were reviewed in person by them within 12 hours of admission.

Multidisciplinary Team working

- There was a daily ward round which had input from medical staff, nursing staff, dietician and physiotherapy. We observed excellent team work on the unit, with effective MDT meetings; everyone was involved, had a voice, and their input was appreciated.
- Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the critical care unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes. There was a dedicated team of physiotherapists and occupational therapists for the unit.
- There was a 0.6 wte pharmacist who worked with the unit five days a week.
- All patients with a tracheostomy were assessed by a speech and language therapist.
- A dietician provided support to the unit.

Seven day services

- At the weekend there is a consultant available 8am to 6pm. They were supported by a senior house officer level doctor.

Requires improvement

Intensive/critical care

- A physiotherapist would attend the ward from 9-11am and 2-4pm. There was an on-call service over the weekend, but this was a limited provision.
- The pharmacy trust on-call service covers holidays and weekends, but this is a limited service mainly covering dispensary issues.
- Outreach service is available 24/7.
- There is not seven day provision from the Speech and Therapy Language Team.
- The nutritional team support is one session per week, but this is not critical-care specific.

Are intensive/critical services caring?

Outstanding ☆

The ICU had some excellent caring interventions in place to support patients, families, friends and staff. Patients and relatives were involved in the care and kept well informed by both medical and nursing staff throughout their care and through dediciated meetings.

Feedback from patients and relatives on the ward and at our listening event was overwhelmingly postive. A volunteer service offers additional support such as manicures and support for relatives.

The units work with aftercare and Insights was nominated for a national award.

The ICU had a bereavement service that was well established to support relatives and held a twice yearly memorial service to remember patients who had died in the previous six months.

Compassionate Care

- The unit had a volunteer service, who offered manicures and nail painting for patients, support to families, and patient visiting.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Relatives we spoke to told us “the staff are very good, they are kind and have a caring attitude” and “we can’t fault them, we could not ask for more from the staff”.
- The majority of feedback from the listening event was extremely positive.
- We looked at patient records and found they were completed sensitively, and detailed discussions with relatives were clearly documented.
- Relatives were encouraged to visit and the visiting hours were open apart from the rest periods each day between 3-4.30pm, when the blinds are closed and the lights set to night setting. Visiting time was at the discretion of the nurse in charge for new admissions.
- The ICU team were also seen to be going beyond their normal duties by taking patients to the physiotherapy gym.
- There was a DVD for relatives and family members to show and explain about ICU care.

Patient involvement in care

- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible, the views and preferences of patients were taken into account.
- The ICU follow up service fed back patient views to the wider ICU team, and patient volunteers also had the opportunity to do this.

Emotional Support

- Following admission to the unit, the consultant covering the unit would arrange to meet with relatives to update them on patient progress. They were given an overview of the intended plan for the patient, alongside what they could expect from the unit. Nursing staff would also attend this meeting.
- When necessary, further face-to-face meetings were organised, and all relatives we spoke with stated that they had been kept fully updated, and had had opportunities to have all their questions answered.
- There is a bereavement service for the ICU. The service had been in place for 15 years. The bereavement team worked closely to support the family and friends of patients on the ICU unit, and provided support for staff.
- There is a memorial service twice a year. At the services they remember patients who had died up to a year and 6 months prior to that date. Families of patients who had been on ICU, discharged elsewhere and then died were also invited. The service is held at a local church and usually has 100-130 attendees. During the service, staff and relatives light candles to represent those who are being remembered. The names of the people are read out aloud and then entered into a Book of Remembrance, which is displayed at every memorial service. There are hymns and readings which are

carefully chosen to reflect all faiths, and those who have none. After the service, tea and cake is provided, which gives an opportunity for people to share their story with others who have suffered an unexpected bereavement.

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

(for example, to feedback?)

Requires improvement

During the inspection period we observed patients waiting several hours for an admission to ICU due to the capacity limitations. An out-of-hours cardiac arrest patient remained in the emergency department resusuitation room for four hours, whilst an ICU bed was made available, with the premature discharge of a medical patient to a ward.

We were advised that planned operations had been cancelled on the day of our visit, due to lack of capacity of ICU beds.

Due to capacity limitations and demands on the service, there are discharges from the ICU between the hours of 10pm and 7am; NICE guidance outlines that discharges should not take place during these hours, and if a discharge from the ICU occurred, it should be reported as an incident. The unit are reporting these as part of their trust KPI returns.

The ICU had bay beds within the Heygroves ward. Due to the capacity limitations, there had been same-sex breaches reported relating to admissions to these bays for patients who were considered able to go to a ward. For the month of February 2014 there were seven same-sex breaches reported.

To try to support post-operative patients, consultants had developed a programme to aid the planning of elective surgical admissions.

Staff facilities on the unit were poor, with the on-call room also being used as an office during the day. The staff room is insufficient in size and facilities for the number of staff working on the unit.

Out-of-hours transfers had taken place to free up beds for emergency admissions. Staff told us they felt they were "fire fighting" to manage the demand on the service, with limited capacity and resources.

Maintaining flow through the department

- Staff told us that patients who were post-operative were being sent home, or back to the ward, too early, due to lack of available ICU beds but there was no record of the number or impact of this on patient experience or safety.
- The ICU had an average of six out-of-hours discharges per month (these are patient discharges which have taken place during the hours of 10pm-7am), according to the data for January 2013 – December 2013.

Meeting the needs of all people

- Support for patients with physical and learning disabilities was available if needed. The trust employed a person to support and assist people who had learning disabilities.
- Interpretation services were available, both by phone and in person.
- The fundraising initiatives had enabled a number of iPads to be purchased for the unit; the iPads had a communication application on them to support patients, who could not speak due to a tracheostomy or tracheal tube, enabling them to communicate with their family members.
- The unit had three rooms available for families who wish to stay while their relative was in ICU. The rooms can accommodate two people, and had facilities such as a fridge, microwave and television.
- There was also a relatives meeting room, which was used for private consultations with families. This room was in need of refurbishment, as it is an old store cupboard which had been converted into a family meeting room. The room had no natural light, but there was a plan to improve this with the use of glass bricks.

Discharge and handover to other wards

- In line with NICE guidance, discharges from a critical care unit should not take place between the hours of 10pm and 7am; however, the ICU has had a monthly average of six out-of-hours discharges from January 2013 to December 2013.
- Prior to discharge, the critical care nurse performs a face-to-face handover of the patient to the accepting ward / team nurse.

Requires improvement

Intensive/critical care

- There was a standardised discharge document that was completed by the critical care unit prior to discharge to the ward. This outlined the treatment received whilst on the unit, as well as a decision regarding whether readmission to the unit would be appropriate. It clearly outlined the discussions that had taken place with the patient and relatives.
- As part of the inspection, we reviewed the ICU draft admissions policy. This had been prepared locally to manage admissions, transfers and discharges from the ICU to intra-hospital and inter-hospital.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the nurse in charge / shift co-ordinator. If they were not able to deal with their concern satisfactorily they would be directed to the Patient Relations Department or Patients Advice and Liaison Service (PALS).
- The critical care matron for ICU received all of the complaints relevant for their unit. They would then speak directly with the staff member involved and together they would write to the complainant offering to meet with them. Timescales for acknowledgement and investigation are outlined in the complaints leaflet. We also saw evidence of the complaints for the unit being monitored by the matron on the monthly KPI returns.

Are intensive/critical services well-led?

Requires improvement

Leadership within ICU locally was good. However, despite a highly motivated team within the service, it appeared that staff felt unsupported in the development of ICU capacity to meet demands and core standards. A business case had been completed for expansion of the unit but the outcome of this was not known at the time of our inspection. The service was challenged daily by pressures of workload and work pattern, and bed availability, and staff told us they felt their duty of care and delivering of quality care was being compromised. They felt they were firefighting to deal with emergency situations daily.

In addition to the core clinical and nursing leadership there were champions with the ICU for specific aspects of care such as privacy and dignity and tissue viability. There was an improved appraisal and supervision for staff and meetings and away days were organised.

The ICU had a team working approach and all staff felt involved, however staff felt instability in the executive team impacted on a the lack of a clear strategic vision for the service and plans for staffing and capacity issues. There was a good governance structure of meetings with staff and care groups.

Leadership of service

- The ICU had a Clinical Lead, Matron, Lead Nurse, Nurse in charge and a number of staff 'champions' (people who take a lead on a particular key area, attending meetings and training courses, and they feedback to the other staff members on updates with guidance and protocols).
- 'Champions' were in place for the ICU in privacy and dignity, continence care, tissue viability, falls, diabetes care, infection control, nutrition and dementia care.
- The service was managed well locally, but worked within the restraints they had regarding bed and staffing capacity. It was evident that the team worked very well together to deliver the care to patients who were staying on the unit.
- Recent introductions of appraisals and supervision had enhanced the support mechanisms for staff.
- The lead nurse had planned away days for team groups and staff meetings were also held.
- The consultant leading the meeting knew every team member by their first name, and respected every team members input; this included over 17 nurses, several junior doctors and other team members.

Culture within the service

- We observed that everyone had a voice within the ICU, and staff were encouraged to use it.
- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility.
- Openness and honesty was the expectation for the department, and was encouraged at all levels.
- There is strong team-based working, characterised by a co-operative, inter-disciplinary approach to delivering care, in which decisions are made by the team.

Requires improvement

Intensive/critical care

- Staff were engaged and worked well with other departments within the hospital.
- Staff and leaders in the ICU prioritise safe, high quality, compassionate care.
- Mechanisms are in place to support staff and promote their positive wellbeing. The ICU had an 80% appraisal completion rate for February 2014.
- Staff told us they felt the ICU was a nice place to work.

Vision and strategy for this service

- Staff felt unsettled by the 'interim' positions within the executive team, stating that they felt no clear strategic direction plan was in place for the trust for ICU.
- The ICU is part of the Urgent Care Group. Staff felt that the directorate had inadequate capacity to care for the sickest patients who passed through the emergency department, acute admissions and critical care. A business case had been put forward to address this, with a new build or an interim solution. Staff reported that there was a lack of decision-making at both Care Group and executive level to address these issues.
- There had been limited support for the expansion in consultant numbers, with one extra consultant appointment planned, as opposed to the four posts requested to meet the Core Standards
- Staff felt there was no visibility of the executive team.
- As a unit and service they have prepared a business case to meet the demands on the service and achieve the core standards. The business case sets out the current and future needs of the service, including resources, qualities and skills required. The executive team were aware of the potential and actual risks to quality, but this business case has not yet been approved.

Governance, risk assessment and quality measurement

- Governance meetings were held within the directorate, and all staff were encouraged to attend, including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed. Examples of audits include the National Cardiac Arrest Audit (NCAA), Outreach audit, TVCCN Tracheostomy Care Bundle audit; in January 2014 this was reported as 50% compliance, but increased to 90% in February 2014.
- A quality dashboard was presented, so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to be able to provide.
- The ICU is part of the Critical Care Network; a peer review of the unit and an action plan is produced following their visit. The action plan is to support and share best practice and recommend improvements.

Innovation, learning and improvement

- Given the trusts financial status it was not evident within the service that a cost improvement plan was in place. There was no ownership within the service to contribute towards a trusts financial strategy plan.
- Staff away days have been planned for all staff groups.

Requires improvement

Maternity and family planning

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

Information about the service

A full range of maternity services is provided at the Royal Berkshire Hospital, which include:

- Rushey midwifery-led unit
- Iffley ward antenatal, postnatal and transitional care
- Marsh ward postnatal
- Delivery suite
- Antenatal clinic
- Day assessment unit
- Community midwifery
- Ultrasound department
- Willow bereavement room

During 2012/13 there were 5833 hospital deliveries and 5939 births (includes mutiple births) at the Royal Berkshire Hospital plus and 143 home births.

The delivery suite comprises ten delivery rooms, a room with a birthing pool, and another room used for delivering known as the 'home from home' room. There are two operating theatres, and three rooms used for women who require a higher level of care, but are not in labour. The day assessment unit is adjacent to the delivery suite, and comprises of four rooms. All inductions commence on the day assessment unit – up to a maximum of four per day. and pre-operative assessment also occurs here.

Rushey Midwifery-led unit is a labour unit comprising of four rooms and is located on the sixth floor, adjacent to the neonatal unit (NNU), Buscot ward. Triage occurs here in one of two additional rooms.

Iffley ward provides antenatal, postnatal and transitional care, and Marsh ward is a postnatal.

Community services are provided by four teams of community midwives. Satellite antenatal clinics are held once a week at both West Berkshire Community Hospital and Wokingham Hospital, and obstetric ultrasound sessions are held twice weekly at West Berkshire Community Hospital. Multi-professional antenatal clinics are held at the Royal Berkshire Hospital. A consultant who specialises in fetal medicine has twice weekly sessions within the ultrasound department.

Requires improvement

Maternity and family planning

Summary of findings

Midwifery staffing levels were found to be insufficient to provide a consistently safe service, especially on Rushey ward. However, following our announced inspection, the trust closed two beds to manage capacity and associated safety risks. Medical staffing did not meet the recommended national guidelines for consultant presence on the unit. The ventilation system within the delivery suite had been identified as not meeting standards expected, which meant that staff were potentially at risk from inhalation of excess nitrous oxide. Essential maintenance of equipment would often take some time to occur. Baths on Rushey ward were used to labour and deliver in, and evacuation equipment in the event of a sudden maternal collapse was not available in these rooms; however, the trust closed these rooms following the announced inspection, until a formal review could be carried out regarding their safety.

Instrumental and caesarean section rates were higher than expected. Inductions of labour were subject to delay due to workload pressures. The maternity service had a policy to divert women to neighbouring trusts due to lack of capacity or high workload, which was implemented at least once per month. At these times the home birth service could also be suspended.

Care was delivered with kindness and compassion. Patients and their partners were involved, and emotional support was good, particularly in times of bereavement. There was a visible and supportive midwifery and obstetric management team and there was an open and honest culture with well-defined governance structure.

Are maternity and family planning services safe?

Inadequate

Significant improvements were required in order to ensure that safe care was delivered to all women at all times.

Midwifery staffing levels were insufficient to provide a consistently safe service. In order to provide one-to-one care in labour, midwives were taken from the ward areas and the community, leaving them under-resourced for the work they had to undertake. As a result, medicines and observations were at risk of being delayed. Activity on Rushey ward far outstripped its capacity with the current midwifery staffing.

Midwives were undertaking triage whilst also carrying out the duties that should be done by the ward clerks or support workers. Women were, at times, left unobserved in waiting areas whilst midwives attempted to find them a bed on the delivery suite. Additional staffing had been recommended following both internal and external reviews undertaken as a result of a cluster of deliveries, where babies were born in an unexpectedly poor condition. In addition, it was recommended that a band 7 midwife be in charge on each shift. This had yet to be put into action, despite the cluster of incidents occurring eight to nine months ago.

During our inspection we were sufficiently concerned about the staffing levels that we raised this with the executive team. They immediately responded to our concerns and closed two of the beds on Rushey Ward within 24 hours.

Cleanliness, Infection control and hygiene

- Ward areas appeared clean, and we saw staff regularly wash their hands and use hand gel between treating patients.
- 'Bare below the elbow' policies were adhered to. Hand gel dispensers were outside all doors, with signage advising staff and visitors to use it.
- There were no recent cases of MRSA and C. difficile.

Requires improvement

Maternity and family planning

Midwifery Staffing

- Births to midwife ratio was 1:35 across the organisation; however, the midwife to birth ratio on Rushey ward was considerably higher, and at times it had been reported as 1:62 due to increased deliveries on Rushey ward.
- Staff were called from other areas to provide one-to-one care for labouring women, which was achieved between 98-100% of the time. In addition to this, 10.2 wte midwives had recently been appointed, but were yet to commence employment. There was an additional vacancy rate of 1.2 wte.
- Following an external review, commissioned as a result of a cluster of deliveries with babies born in poor condition, it was identified that an additional six midwives were required on Rushey ward. The incidents had occurred eight to nine months ago. The external review reported their findings in January 2014. A business case had been agreed by the Urgent Care Board to recruit additional midwives; however, this was yet to be approved by the trust and the staffing shortfall remained at the time of the inspection.
- The external review identified the need for a band 7 midwife to be in charge and co-ordinating for all shifts on Rushey ward. This was still not in place for all shifts. Midwives worked twelve hour shifts, which meant there were a total of 14 shifts in a week. Only five of the 14 shifts per week were covered by a band 7 midwife from the core of midwives who were on Rushey staffing rota. The other band 7 cover was provided with staff movement throughout the unit to attempt to address this, but there were still occasions when the ward was without a senior midwife.
- The co-ordinator on the delivery suite was supernumerary for most of the time. The delivery suite undertook an activity monitoring tool, as recommended by the National Patient Safety Agency. Activity was recorded every four hours. This showed that the co-ordinator for the delivery suite was supernumerary for 86-96% of the time.
- Staff reported that most newly-recruited midwives were newly-qualified, and therefore employed to undertake preceptorship scheme work before progressing onto a band 6. Whilst accepting this was necessary, staff told us that this added greater pressure to existing and experienced midwives, who were required to support the new midwives in practice.
- Rushey ward staffing levels allowed for two midwives to care for labouring women, one midwife to undertake triage, and one midwifery care assistant. At night, the homebirth midwife and their second (community-based) midwife also attended the unit, if they had no women at home in labour, who were planning a home birth.
- As there was no ward clerk employed for any cover on Rushey ward, the triage midwife also undertook roles that would often be undertaken by them; for example, accessing medical records. Most women attended the triage area before being transferred to other areas, such as the delivery suite or to Iffley ward if appropriate. We saw, at times, there was more than one woman attending who was requiring triaging. We reviewed the activity of one night picked at random, and saw three women had attended in labour, one at 3.05am, one at 3.10am and one at 3.20am. These were all under the care of the triage midwife as there were also two women in labour. The triage midwife was required to keep a log of activity. We reviewed the log which contained large gaps. We were told this was as a result of the triage midwife being too busy to complete the paper log. This meant there was not a clear record of activity, particularly when the Rushey unit became busy.
- During busy times, in order to achieve one-to-one care in labour, midwives were taken from other areas, such as Iffley ward and Marsh ward. Staff there told us that this was a frequent occurrence. We saw from incident reports that at these times, care was often sub-optimal, with delay in the administration of medicines and observations.
- Iffley ward presented their ideal and actual staffing numbers on a safety cross on the ward, and also as a percentage. The agreed midwifery staffing numbers for the ward were set at four midwives on an early shift, four on a late shift, and three on a night shift, supported by one nursery nurse per shift and two midwifery care assistants. Figures for January 2014 showed they only had the correct number of midwives on an early shift for 19% of the time, for a late shift that figure fell to 6%, and for a night shift, 13%. Nursery nurse and midwifery care assistant presence ranged from 90-100%. We saw, at busy times or during periods of sickness, areas were left with insufficient staff. For example, we saw one incident report from Iffley ward in October 2013, which reported a full ward with two midwives, one staff nurse and one maternity care assistant. Agreed staffing levels were for four midwives. The incident report stated inadequate care was given. No support was given to breastfeeding

and first time mothers. There were a total of 19 discharges, five babies were in receipt of IV antibiotics, one baby was receiving phototherapy, and a postnatal mother required a blood transfusion. There were also delays in administering intra venous antibiotics.

- An incident report from October 2013 cited that only one midwife and two maternity care assistants were on Iffley ward for a night shift. On another night, Iffley ward had 14 antenatal women, including two who were being induced, one in early labour awaiting transfer to the delivery suite for artificial rupture of membranes, 11 postnatal women and babies, of which five babies were in receipt of transitional care, including one having intravenous antibiotics, and one having phototherapy. One midwife was taken to work on the delivery suite, leaving only two midwives on the ward. As a result, staff reported not having breaks, and delays had occurred with medication administration, including those prescribed to be given intravenously.
- Sickness levels were higher than other areas within the trust, at 5%, and above the England average of 4.3%. Staff told us people would often become unfit for work as a direct result of the stress they felt from the workload. Medical staff told us that they felt there were insufficient midwives, and that they had a high sickness rate as a result of the pressure they worked under.
- All midwives must have access to a Supervisor of Midwives at all times, (NMC 2004 Midwives rules and standards - Rule 12). The ratio of Supervisor of Midwives to midwives was 1:20. This is higher than the recommended ratio of 1:15 and greatly increased the workload on the Supervisor of Midwives. Supervisor of Midwives are required to carry out annual reviews with all midwives. This had occurred for 93% of the midwives.

Medical Staffing

- There were seven full time consultants obstetricians were employed. Obstetric consultant cover on the delivery suite ranged from 68-91 hours, which was below the recommended standard of 168 hours of consultant cover each week. None were employed to also cover gynaecology. However, junior staff were shared between both specialities.
- There was a requirement for dedicated anaesthetic consultant cover to be present on the delivery suite for a minimum of 50 hours a week. This was not being met on most weeks, with 46.4-47.8 hours cover being provided. However, a consultant anaesthetist was present on the delivery suite Monday-Friday 8am–6pm. Out of hours, there was always a consultant on-call. Trainees received daytime supervision by the consultant anaesthetist on the labour ward. Staff we spoke with felt that consultant anaesthetists readily attended out of hours.
- Junior doctors told us that there were adequate numbers of junior doctors on the wards out of hours, and that consultants were contactable by phone if they needed any support.
- Whilst midwifery staffing levels did not change across the week, medical staffing was reduced at weekends. Consultants were, however, on-call, and it was recognised they were always available, and that they had a low threshold to attend. However, consultants did not always routinely visit the wards frequently. This meant that some women, who were admitted antenatally, did not see a consultant during their inpatient stay.

Nursing and Medical Handover

- Midwifery handover occurred at the beginning of each shift. Medical staff undertook handovers on the delivery suite. The handover was structured and detailed issues of concern.

Management of the deteriorating patient

- The unit used the Modified Obstetric Warning Scoring System. Staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts, and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- Staff undertook 'fresh eyes' on the delivery suite. This is a structured review of electronic fetal monitoring by someone other than the midwife providing care, and was required to occur hourly during labour. However, this did not always occur on Rushey ward when patients needed continuous monitoring.
- Staff used the SBAR communication tool when handing over or discussing concerns (Situation, Background, Assessment, Response).
- A few staff on the delivery suite had undergone the high dependency course through the University of the West London to increase skills of HDU care.

Safety Thermometer

- Safety thermometer information was clearly displayed on the wards. This included information about all new

harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers. In addition, required and actual staffing levels were publicised on Iffley ward, along with medication incidents.

Incidents

- There had been no recent 'never events' reported. A 'cluster' of deliveries with poor neonatal outcomes were identified over a period of two months on Rushey ward. As a result, an internal investigation was undertaken. Meetings were held with staff on the ward, chaired by senior members of the midwifery team, and findings were shared with staff. Staff felt the process had been open and responsive. Learning had been identified, and action had been put in place. For example, all staff were now fully trained in the use of the resuscitaire devices on the ward, which differed from those used on the delivery suite, and simulation training occurred on Rushey ward as well as on the delivery suite.
- The results of serious untoward incidents were shared with staff through maternity governance and clinical risk meetings. Minutes were shared with staff, and learning as a result of them became part of the annual professional study day for midwives.
- Where serious incidents occurred, senior staff offered to meet with parents and share the investigation reports.
- All staff we spoke to stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at monthly clinical risk and governance meetings. Where necessary, supervisors of midwives were involved in practice and performance issues identified as a result of incidents.
- Staff reported clinical incidents such as 3rd and 4th degree tears, retained placentas, and unexpected admissions into the neonatal ward. The frequency of these were then monitored to identify trends. As a result, changes were implemented. For example, there had been an increase in perineal wound infections. Cleansing solution had been changed and staff had been reminded of the need to inspect perineums during the postnatal examination.
- Incidents relating to extreme workload, or reduced staffing levels, were inconsistently categorised. Some incidents were recorded as incidents affecting the organisation, some as incidents affecting staff, and some as incidents affecting the patient. A lack of a consistent approach to the recording of incidents where staffing levels were sub-optimal, and affecting patient care and safety, meant that an overview could not be seen and monitored.
- Staff received feedback from incidents at ward and department meetings. Minutes of ward meetings were also produced and sent to staff, as well as being placed on a shared drive.

Environment and Equipment

- The labour ward had an insufficient scavenging system to remove used nitrous oxide from the air (produced when using entonox). This was identified following an external report which identified a risk to patients and staff. This was placed on the risk register in April 2013, and was categorised as a major risk. There was no date identified at which this was to be addressed and women continued to use entonox throughout their labours as required. This meant that staff would potentially be exposed to higher than expected levels of nitrous oxide.
- Wards and the delivery suite were accessed through a locked door, controlled by a buzzer, with CCTV observation. Staff wore identification badges containing their photographs. We observed people being questioned before they were allowed entry. However, the risk register referred to a security incident in November 2013, where a back stairway giving access to a postnatal ward had been found to be unlocked. The continuous alarm had been silenced, meaning that staff were not alerted to the issue. Staff had been informed to be vigilant. A further incident occurred, and despite escalating concerns to the director of estates, a formal response remained outstanding in February 2014.
- Equipment was appropriately checked and cleaned regularly. We saw emergency resuscitation trolleys had been checked thoroughly daily, and records were maintained to demonstrate this. There was adequate equipment on the wards to ensure safe care (specifically cardiotocography (CTG) and resuscitation equipment). However, staff we spoke with identified concerns regarding maintenance and repair of essential equipment, particularly sonacaids used for listening to the fetal heart in the community, and prior to placement of a CTG. Where these had required repair, staff reported periods of 2-3 weeks where they were required to share equipment with their colleagues. We also saw incidents

reported where staff were unable to monitor all babies via a fetal scalp electrode when it was necessary. As a result, abdominal monitoring was used until 'a lead' had become available as a result of a delivery.

- Rushey ward had four delivery rooms, one of which had a birth pool and two of which had large corner baths. Midwives we spoke with described using the baths frequently when women were in labour, and also conducting the delivery of some women in them. There was one net for the emergency evacuation of a collapsed woman out of the birthing pool. This was stored in the delivery room within easy access. However, no emergency evacuation equipment existed in the rooms with corner baths. When asked how evacuation would be conducted should a woman collapse in the bath, staff told us they would use a sheet and had practised with this. This potentially placed the health and safety of both women and midwives at risk. This was raised with the executive team during the announced inspection, and they closed the two rooms on Rushey ward to prevent these rooms being used for women to labour in the bath, until the risks and mitigations had been assessed more thoroughly.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Staff who administered IV antibiotics to neonates received additional training.
- The midwives exemption list meant midwives were able to administer medicines such as diamorphine and entonox to women in labour.
- Emergency O negative blood and a paediatric blood supply were stored in a blood fridge on the delivery suite. A Bar coded system was in operation for tracking and monitoring usage. Stock and storage was the responsibility of the transfusion department.

Records

- All records were in paper format and all health care professionals documented in the same place. Women were given hand held records at booking. These were added to at each visit to a healthcare professional.
- Care pathways for first stage and second stage of labour were used in all areas.
- Postnatal records were created following delivery, containing all details of the mother and baby, including mode of delivery, blood loss and the neonatal check. These records accompanied the woman on discharge and were used by the community midwife during all home visits. On discharge from the service, these records were returned and 'married up' with the woman's medical records.
- All midwives and doctors had a stamp of their name and registration number. This made it clear who had made each entry.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately and correctly. At the time of the inspection, there were no women who did not have capacity to consent to their procedure.

Mandatory Training

- We looked at staff mandatory training records, and compliance with mandatory training was good.
- Staff stated that they had good access to training and received four mandatory training days per year, covering obstetric emergency skills training, neonatal and adult resuscitation, and a professional day which covered any new and 'hot topics'.
- Midwives were also required to undertake CTG training every three months.
- Compliance with training was good, and was linked to incremental pay progression.
- Midwives who were newly-qualified undertook a period of preceptorship, which lasted at least nine months. During that time they were able to attend monthly supervision sessions. They were also required to complete all mandatory training and to be assessed as competent for skills such as cannulation and perineal suturing. Newly qualified midwives spoke highly of the support and access to training they received during this time.
- Data received from the trust showed compliance with mandatory training to be significantly lower than that evidence of compliance being reported by the service areas.

Requires improvement

Maternity and family planning

Are maternity and family planning services effective?
(for example, treatment is effective)

Requires improvement

The maternity service required improvement in order to be effective. Guidelines were written in line with national guidance, and policies and procedures were updated as practice changed. New learning was fed into the midwifery professional learning days.

The service had a dashboard, but few staff beyond senior staff were aware of it. Instrumental and caesarean section rates were higher than expected; this not only increases the costs to the service, but also the risk to women and babies. Inductions of labour were subject to delay due to workload pressures. In one month postponement of planned inductions occurred 72 times. The home birth service had, on at least two occasions, been suspended. The homebirth rate was below the Clinical Commissioning Group (CCG) target but on a trajectory to meet it.

Staff worked well together, and there was a well-resourced multidisciplinary team, meaning that the requirements of women with medical or complex health or social needs were met. Communication was felt to be good. This meant that women in greatest need received the care and support they required to meet their needs.

Failure to maintain and repair equipment in a timely manner meant that the service was unable to run effectively at times.

All forms of pain relief were available to women, including a 24 hour, seven day a week epidural service.

Use of National Guidelines

- The Maternity unit used nationally-recognised guidelines (for example, Safer Childbirth: minimum standards for the organisation and delivery of care in labour) to determine the treatment they provided. Local policies were written in line with this, and were updated if national guidance changed.
- At the monthly departmental meetings any changes to guidance, and the impact that it would have on their practice, were discussed. Changes also featured in the annual professional day. In addition, the delivery suite had a board where a 'Topic of the month' was available for all to read.

Outcomes for the unit

- The maternity service had a quality dashboard which was reviewed monthly at the governance meeting; however, junior medical staff were unaware of its existence.
- The normal delivery rate (58%) was below the England average (61%).
- The elective caesarean section rate at 11.8% was higher than the England average (10.7%). The emergency caesarean section rate was comparable with the England average (14.8% against an England average rate of 14.5%). When questioned, one member of staff indicated that there was a pressure to carry out caesarean sections for non-clinical reasons, due to the ward pressures.
- Instrumental delivery rates overall were also higher than the England average (14.5% compared to 12.7%). When questioned, medical staff spoke of the difficulty in supervising all deliveries to support decisions and modes of delivery.
- Puerperal sepsis and other puerperal infections were higher at 149 for the period July 2012-July 2013, than would be expected at 124. Staff told us that midwives had been reminded of the need to view perineal and abdominal wounds for signs of healing during the postnatal examination.
- 22-23% of all deliveries occurred on the midwifery led unit (Rushey ward). Rushey ward also had a transfer rate in labour to the delivery suite of 28%. Of these, 28% were for delay in the second stage of labour, exceeding the national birth place study findings which reported a 16% rate for transfer due to second stage delay. Staff had identified their transfer rate as being high, and were undertaking a retrospective audit. Early findings indicated misdiagnosis of the second stage of labour as being a factor in some of the transfers. However, concerns were also raised by some staff that transfer to the delivery suite did not occur soon enough in some cases.
- The unit homebirth rate was currently 2.4%, against a target set by the Clinical Commissioning Group of 5%.

- Vaginal birth after caesarean section (VBAC) rate was 72%, against the CCG target of 60%, which meant that more women achieved a VBAC.

Care Plans and Pathway

- A Female Genital Mutilation (FGM) pathway, led by the social inclusion midwife, had been developed.
- Women who had undergone a previous caesarean section were seen in the early stages of their pregnancy, in a clinic staffed by midwives, to allow time to discuss options and modes of delivery.
- Where elective sections were planned, women attended pre-operative assessment in the day assessment unit.
- Plans of care were written with clear instructions when women were admitted antenatally, or experienced complications, such as major obstetric haemorrhage post delivery.
- There were two separate partograms for the 1st and 2nd stages of labour. These were charts used to monitor progress and record observations in labour. Each gave guidance as to normal progress. We saw these had been used in the care records reviewed, with the exception of one. In this instance, delivery occurred within five minutes of the woman entering the delivery room.

Multidisciplinary Team working and working with others

- Relationship with pharmacists, physiotherapists, neonatologists, anaesthetists and other members of the multidisciplinary team was described as very good.
- The service employed two diabetic specialist midwives, one antenatal screening co-ordinator, one newborn screening co-ordinator, one substance misuse midwife, and one HIV specialist midwife, who all worked within the antenatal clinic.
- A community diabetologist worked alongside the obstetric team, providing care for women with diabetes and gestational diabetes, and there was an anaesthetic clinic for women identified as high risk, to plan their needs for labour and delivery.
- The community team and Rushey ward were managed by the same matron. Both areas worked the same shift patterns, and midwives from the community often worked on Rushey ward.
- The midwife-led unit and delivery suite used the same policies and procedures ensuring a continuity of care.
- Iffley ward had the facility to provide transitional care to babies. This included the administration of intravenous antibiotics on the ward. There was good communication between both areas, and the nurse practitioner from the neonatal unit had provided education and support to midwives when they began to administer intravenous antibiotics. This resulted in a better experience for women, as it meant that they could remain on the ward, rather than having to attend Buscot ward twice a day.
- Midwives were trained to undertake the newborn and infant physical examination (NIPE); however, support was always available for the neonatal medical staff.
- The HIV specialist midwife attended monthly multidisciplinary meetings with staff from the department of sexual health, to plan the care for this group of women.
- At the time of the unannounced inspection, the bleep system throughout the unit had failed. Staff were using walkie talkies and mobile phones to communicate in line with the bleep policy. The issue was quickly rectified. The senior midwife in charge of the unit that day ensured that all staff were aware of how to contact each other in the envent of an emergency.

Pain relief

- Entonox, TENS (transcutaneous electrical nerve stimulation) and diamorphine were available for analgesia in labour, as was water in the birth pool on Rushey ward. Rushey ward also provide intradermal sterile water injections as pain relief for women in labour who were experiencing back pain. Though not yet recognised by NICE, as a result of the success of this trial, the practice was just commencing on the delivery suite, though at the time of the inspection, few midwives had undertaken the addition training required.
- Epidurals are available 24/7, with a dedicated anaesthetist who was based on the delivery suite

Seven day services

- Midwifery staff across the unit were unchanged during the week. At weekends, obstetric and anaesthetic consultants were on-call and available for advice as required. Obstetric Consultant presence did not meet national recommendations of 168 hours per week. Staff reported that they had a low threshold for attending the delivery suite out of hours.

Are maternity and family planning services caring?

Requires improvement

Maternity and family planning

Good

The maternity services were caring. Care was delivered with kindness and compassion. Patients and their partners were involved, and emotional support was good, particularly in times of bereavement.

Compassionate Care

- In the CQC Maternity service survey 2013, 196 women were asked about their care at the hospital. There was a poor response rate; however, from the responses seen, the trust compared about the same as other trusts for all aspects of maternity care, including antenatal, during labour and birth, and in the first few weeks after birth.
- The Friends and Family Test was being carried out, with 75% of respondents being happy to recommend the service to their friends and family. The response rate was currently 13.5%.
- Throughout our inspection, we witnessed women being treated with compassion, dignity and respect. We saw that call bells were, in the main, answered promptly.
- We looked at patient records and found that they were completed sensitively and detailed discussions that had taken place with women and their partners.
- The unit held a bereavement service each year to allow families and staff to spend time and reflect.

Patient involvement in their care

- Women we spoke with stated that they had been involved in decisions regarding their choice of birth location, and were informed of the risks and benefits of each. They felt that once they had made the decision, they had been appropriately supported.
- Women carried their own records throughout their pregnancy and postnatal period of care. These contained information as well as contact point details, and were used by all staff to document care.
- The maternity services liaison committee met quarterly, and regularly sought the views of women. This was carried out by the chair of the group visiting the wards and talking to women.

Emotional Support

- The trust employed a specialist bereavement midwife, who provided support to parents and staff alike. There was a bereavement room on the delivery suite, and a room on Iffley ward which was used for antenatal and postnatal stays.
- In the event of a stillbirth, or unexpected death, women either remained in Willow room, the dedicated bereavement room on the delivery suite, or else they returned to Iffley ward to a 'home from home' bereavement room, away from the postnatal areas.
- Written information was available for women in the room, allowing them to look at and take in information in their own time. We saw a diary used by women to write their experiences. Partners were encouraged to stay as long as required.
- Chaplaincy care was available. Support for other faiths was arranged as required.
- Whilst acknowledging the role was, at times, difficult and stressful, midwives and medical staff spoke of good team work, support and of enjoying coming to work.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Requires improvement

The maternity service is not responsive to the needs of the population and requires improvement.

There was good access for women to the service. Vulnerable women were particularly well supported by the Poppy team. This meant they were more likely to access the right care and attention.

Rushey ward had a good range of equipment; however, there was far less equipment available on the delivery suite. This limited womens choices with regards to positions for labour and delivery.

The maternity service had a divert policy, which was implemented at least once per month, often due to a lack of capacity or high workload. This meant that women had to travel to neighbouring organisations in order to deliver their babies. At these times, the home birth service could also be suspended, again removing womens choice. Most women attended for triage through Rushey ward. In

addition, the ward performed 23% of deliveries in only four delivery rooms. This meant throughput was consistently high. Women were, at times, required to wait in the waiting area whilst a bed was sought, particularly if a third women attended for triage, as there was only two rooms. This meant labouring women were at times unsupervised. We saw this had occurred for one women during the period of our inspection. The woman had progressed to full dilatation whilst in the waiting area.

Access

- We reviewed the incident forms and spoke to staff about the frequency that women were diverted to other units. From the incident forms viewed, we saw that the unit went onto divert at least once a month.
- Since opening 18 months ago, Rushey ward had not closed to admissions.
- The home birth service had been cancelled on at least two occasions in the last six months due to there being insufficient staff, and the unit went onto divert at least once per month. This meant women who were telephone the unit in labour were diverted to other units in the area for care and delivery.
- Performance data taken from 2012/13 showed that 89% of women were booked (attend their first appointment in their pregnancy) before 13 weeks gestation against a target of 90%.
- In the six months prior to the inspection, planned inductions of labour were postponed from between 23 and 72 times per month, due to a lack of staffing, or unit capacity issues.
- Partners were encouraged to visit, and visiting times were waived for mothers in labour. Overnight facilities were available for partners in the event of a stillbirth or neonatal death.
- A VBAC clinic was just about to commence in order to allow women access to information on the mode of delivery choices earlier in their pregnancy.

Equipment and facilities

- There was a good range of equipment on Rushey ward for women to use in labour, including birthing balls, birthing couches, mats and a birthing pool. Beds were housed in the walls, but could be pulled down when required. Should suturing be required, Rushey ward had a suturing bed to allow examination and suturing to occur. There was a couch for transfers to the delivery suite, and an additional resuscitaire device, should a delivery occur in the triage area.
- Women delivering on the delivery suite had less equipment available. The birthing pool was out of use due to a maintenance issue. There were no birthing couches, and we did not see any birthing balls during our visit. Rooms were laid out with a bed in the middle, meaning there was also less space for the labouring woman to mobilise. Each room had a chair for the use of partners during the labour.
- Birth partners were encouraged to stay with the woman when in labour; however, unless the woman had a stillbirth, facilities did not exist for partners to remain for a prolonged period after delivery. If women had a single room then partners were able to stay.
- When facilities or equipment became faulty, repair or replacement was often delayed. Staff told us that water had not been hot for several weeks during the winter period. This meant that women were unable to have a bath or shower during their stay. Other staff spoke of having to share vital equipment, such as sonacaids, whilst theirs were being repaired.

Maintaining flow through the department and discharge planning

- Midwives had been trained to perform the neonatal examination, and 99% of babies had received their newborn and infant physical examination (NIPE) within 72 hours.
- The day assessment unit is open Monday to Friday 7.30am-6pm, and Saturday mornings. Women with both antenatal and postnatal problems are assessed and treated in this area.
- Midwives told us that discharge was often delayed due to waiting for medicines to arrive from the pharmacy.
- During busy times, staff told us they 'pulled staff' from other areas to provide support. The main need for midwifery support was to enable one-to-one midwifery care for women in labour. This often meant midwives were taken from the postnatal wards, which in turn resulted in delays in performing discharge checks and discharging women.
- Whilst only having four delivery rooms, Rushey ward undertook 23% of all deliveries. Throughput in this area was consistently high. Staff told us that despite having four rooms, the original intention had been to only use

two rooms; however, staff did not want to turn women away and transfer them to the delivery suite if there was a vacant room on Rushey ward. The unit had a policy entitled 'planning place of birth' which set out the criteria for women to deliver either at home or on Rushey ward. This criterion included the need to be at between 37-42 weeks gestation. We spoke to one woman and her partner who had delivered on Rushey ward at 36 weeks. We also read their notes, which reported the 'unit currently full'. The woman spent one hour in the lounge / waiting area on Rushey ward, before being transferred to a delivery room. During that time, she reported feeling nauseous, and was contracting 1-2:10 (1-2 contractions every ten minutes). This was the fourth time she had presented to the unit. During that time, she had not been observed by a midwife.

- We met one woman who had delivered early that morning. We were told the staff were busy on Rushey ward, and that following triage, she had requested an epidural. Despite it being her second baby, and being in an advanced stage of labour, she was moved out of a triage room into a waiting area, where she rapidly progressed in labour. Rapid transfer to a delivery room on Rushey occurred, and she quickly progressed to have a normal delivery. Both mother and baby were well; however, immediate transfer to a delivery room from triage should have occurred. At the time, all other midwives on Rushey were with other labouring women.
- In reviewing incidents, we noted that the homebirth service had been suspended on two occasions due to a lack of midwives.

Meeting the needs of all people

- There was a team of midwives (known as the Poppy team) who looked after vulnerable and hard to access women in the community, including pregnant teenagers, and those with drug and alcohol misuse. Staff spoke highly of the team, citing good communication from them, to allow hospital midwives to provide appropriate care to meet the woman's needs. This team worked closely with social services, and other members of the multidisciplinary team.
- Women attended Rushey ward to be triaged prior to admission or delivery. We saw a 'green spot' notice had been placed on the back of the toilet doors, with the instruction to women to place a green spot sticker on the base of their urine sample pot to indicate they would like to discuss something with a midwife in confidence.
- Translation facilities were felt to be good. Iffley ward had a welcome sign written in several different languages. The service employed several midwives who were Polish, as well as some asian speaking midwifery care assistants, who worked in the community. A translation line could be used, and translators could be booked to attend with women if necessary.
- Antenatal education sessions were run for women whose main language was Polish. Polish speaking midwives ran these sessions, which covered antenatal care, place of birth, analgesia and postnatal care.
- There were several information leaflets available in the main languages spoken in the community; however, it was recognised that the views of women whose first language was not English were not always sought.

Communication with GPs, other providers and other departments within the trust

- Upon discharge from the maternity unit, antenatal women were given back their hand held records, and postnatal women were given a set of postnatal records. Both detailed what had happened during their inpatient stay, and both contained clear instructions on how to access help and support from their community midwives. A discharge summary was sent to the GP by post on discharge from the department. This detailed the reason for admission, any investigation results and treatment undertaken, and postnatal information.
- The child health record (red book) was given out to new mothers on the delivery suite.
- Postnatal care continued in the community. Postnatal records contained details of both mother and baby.

Complaints handling (for this service) and learning from feedback

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift co-ordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint.

Requires improvement

Maternity and family planning

- The matron for the maternity unit received all of the complaints relevant for her unit. She would then speak directly with the staff members involved and formulate a response. Complaints were reported on and monitored through the governance meetings, and were shared at ward and team meetings. We saw how practice had changed as a result of a complaint. Babies on the postnatal ward in receipt of intravenous antibiotics used to be taken to Buscot ward to receive their medication. As a result of the complaint, paediatric staff had worked with the maternity service to enable the drugs to be administered on the ward by midwives who had received additional training to undertake the role.

Are maternity and family planning services well-led?

Requires improvement

Staff spoke of a visible and supportive midwifery and obstetric management team. Staff were encouraged to incident report, and there was felt to be an open and honest culture, meaning staff could raise issues and report incidents without fear of blame.

There was a well-defined and organised governance structure within the unit; however, issues identified and raised were not always addressed; for example, staffing and skill mix concerns. The maternity services reported into the Urgent Care board; however, their concerns did not appear to progress beyond this as the networks appeared to work in 'silos'. This meant that serious risks, such as the ventilation system on the delivery suite, and staffing and skill mix, were not resolved. Few staff we spoke with told us of ongoing audits or audit involvement, indicating this was not part of the day-to-day running of the service.

Leadership of service

- Staff spoke of a visible senior midwifery and obstetric team. They knew who led the service, and felt the service was promoted well within the trust by them.
- Most senior nurses were aware of the leadership structure above the Urgent Care Network; however, this was less well known amongst more junior staff.

Culture within the service

- Staff were aware of the whistleblowing policy, and were encouraged to raise any concerns they may have. One staff member told us "nothing is brushed under the carpet here".
- Staff worked well together and there was obvious respect between, not only the specialities, but across disciplines.
- Staff within the directorate spoke positively about the service they provided for patients. Staff were very proud of the Rushey ward and the amount of uptake it had generated.

Governance and measurement of quality

- The maternity service had a risk management strategy which fed into the trust risk management strategy, and detailed how risk was managed with the service.
- Monthly maternity governance meetings were held. This meeting reported directly onto the Urgent Care group governance meeting. The following meetings were also held across the service which reported into the maternity governance meeting: the maternity clinical risk meeting, maternity audit meeting, perinatal mortality and morbidity meeting, midwifery service committee, maternity patient information group, maternity services liaison committee and the Supervisors of Midwives meetings. A quality dashboard was presented at each maternity governance meeting; however, when asked, most staff were unaware of its existence.
- Staffing levels were below that recommended by both an internal and an external review, several months after issues were identified. Risks categorised as red (serious risk) were also on the risk register for up to a year; for example, the ineffective scavenging system for the removal of nitrous oxide from the air. These concerns were raised through the departmental governance system, but appeared to stall once reaching the Urgent Care board meeting.
- There was a view that the directorate care groups did not work in collaboration, with 'silo' working being described, which was not conducive to shared visions or learning. Staff in the maternity service were unaware of incidents, or complaints and learning that could have been identified in other parts of the hospital.

Innovation, learning and improvement

- The delivery suite had a notice board entitled 'Topic of the month'. At the time of the inspection, the topic of the

month was the use of sterile water injections for the relief of back pain in labour. This had been trialled on Rushey ward, and was felt to be a success. As a result, the practice was just about to be rolled out onto the delivery suite. Previous topics of the month had included water births. The topic of the month for April was planned to be anti-D administration. All staff were encouraged to be involved in this.

- The consultant midwife had weekly clinics to discuss mode of delivery for women who had previously delivered by caesarean section, or were requesting a caesarean section after a previous traumatic birth. This was also to include women having their first babies', who were requesting an elective caesarean section, in an attempt to address their concerns.
- Breastfeeding clinics were held Monday to Friday within the maternity unit. The unit employed infant feeding co-ordinators, who supported breastfeeding and ran the clinics. The clinics were well attended, with between six and eight women attending per day. This clinic was available for women for six weeks after delivery. Marsh ward hosted 'tele time' twice daily at 11am and 4pm, during which women and their partners could watch two short programmes: 'About breastfeeding' and 'About formula feeding'.
- A service to assess and treat babies with tongue tie was run within the breastfeeding clinic. Specially trained midwives were available to assess and perform frenulotomy.

Good

Services for children & young people

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

Information about the service

A full range of hospital paediatric services is provided at the Royal Berkshire Hospital, which include:

- General paediatric inpatient and outpatient services (included in the review of outpatient services)
- Children's Accident and Emergency (included in the review of Accident and Emergency services)
- Paediatric short stay unit
- Kempton day bed unit
- Paediatric high dependency unit
- A general paediatric ward (Lion and Dolphin ward)
- Paediatric oncology shared care service
- Community paediatrics and neurodisability
- Level 2 (local) neonatal unit (Buscot ward)

Lion and Dolphin ward comprises of five HDU beds and 39 beds / cots, in a combination of bays and single cubicles, with provision for a parent to sleep next to their child if they wish. The ward takes all acute medical, surgical and orthopaedic admissions; there are two isolation suites for oncology patients.

Kempton day bed unit has 10 beds and caters for children requiring day-case surgery, and paediatric medical patients attending for a wide variety of things, including investigations, intravenous medications and transfusions, allergy challenges and Botox injections. The Kempton day bed unit also provides a paediatric phlebotomy service.

The neonatal unit, Buscot ward, has 21 cots with three designated as intensive care and five as high dependency care. The Unit is a designated local neonatal unit ('level 2') in the South Central North Neonatal Network. At the time of the inspection, only 14 cots were open, due to remedial works on the medical gases.

The paediatric department is overseen by 10.5 whole time equivalent (wte) acute consultant paediatricians and five consultants in community paediatrics. Two additional acute paediatric consultants have recently been recruited.

Good

Services for children & young people

Summary of findings

Babies, children and young people were cared for in wards and departments that were clean. Infection control practices were adhered to. There were sufficient nursing and medical staff across all areas. Staff used recognised early warning systems for both neonates and paediatric patients. Staff reported incidents, and learning was shared across the area to prevent the likelihood of a reoccurrence. Security for patients and staff within the neonatal and paediatric areas was good. Access to mandatory and additional training support was available to staff, to allow them to develop additional skills.

Care and treatment was delivered in line with national guidelines. Outcomes were reviewed, and there was active participation in research and audit. Care plans and pathways were in use. Multidisciplinary team working was good in all areas.

Staff provided care in a kind and compassionate manner. Parents were involved in both decision-making and the delivery of care and were provided with appropriate emotional support.

There was a highly visible leadership team and the culture was found to be open and supportive.

Are services for children & young people safe?

Good

The Children and Young Peoples services provided by the Royal Berkshire NHS Foundation Trust were found to be safe. Babies and children were cared for in wards and departments that were clean. Staff received infection control training and we saw infection control practices being adhered to. This meant that the likelihood of babies and children catching infections was reduced.

There were sufficient nursing and medical staff across all areas; however, it was recognised that there was a need for additional middle grade medical staff cover in order to adhere to the neonatal toolkit for determining appropriate staffing levels and provide dedicated middle grade cover for both paediatrics and the neonatal unit at night. The current staffing arrangements mean there is a risk that delays in obtaining senior medical assistance could occur.

Staff used recognised early warning systems for both neonates and paediatrics, designed for early identification of the deteriorating patient. Correct use of these tools was audited and formed one of the key performance indicators. An outreach service operated 24 hours a day, seven days a week, providing advice and support to nursing and medical staff on the paediatric wards. This meant that deteriorating patients were likely to be identified sooner, and staff had access to appropriate advice and support to manage the needs of these patients.

Staff reported incidents, and incidents were investigated. Learning was shared across the area to prevent the likelihood of a reoccurrence. The paediatric department had reported one serious incident in the last six months, which was being investigated at the time of the inspection. However, the member of staff undertaking the investigation had not received any training in root cause analysis, however there was support from the unit matron.

Security for patients and staff within the neonatal and paediatric areas was good. Areas were clean, bright and appropriately decorated for children of varying ages. Equipment was available, stored safely and was cleaned

between uses. It was noted that repairs and maintenance of equipment was often subject to significant delays, which could have an impact on patients care and experience. Facillities for parents to stay were found to be good.

Medicines were stored securely. Staff reported medication errors, and actions were put in place where medication errors occurred. However, oxygen therapy was not prescribed on Lion and Dolphin ward. The safety of the patient is at risk if oxygen is not prescribed when clinically indicated and therapy is not adequately monitored to achieve the correct target saturations.

Medical records for frequently attending patients, who had an 'open door' invitation, were kept on the ward. Other records were obtained from medical records. There was often a delay in accessing these records, which meant staff did not have details of previous nursing and medical care.

Patients consent was obtained appropriately and correctly. Systems and proceses were in place to ensure the safeguarding of children.

Most staff had accessed mandatory training, and additional training and support was available to staff to allow them to develop additional skills.

Cleanliness, infection control and hygiene

- Ward areas appeared clean, and were tidy and free from clutter. We saw that staff regularly wash their hands and use hand gel between treating patients, and adhere to specific infection control measures when entering a side room that contained a patient who was being barrier nursed.
- Patients with known infections, or those who were at risk due to being immunocompromised, were nursed in cubicles, which all had en suite toilet facilities.
- 'Bare below the elbow' policies were adhered to. Staff told us they actively challenged anyone who did not follow this policy in the clinical area.
- Audit for the screening on admission for MRSA on Lion and Dolphin ward showed that this was being carried out on only 50% of patients admitted; however, there had been no recent cases of MRSA septicaemia on the ward. This information was printed on a board on the ward, reminding staff of the need to improve their screening rates. The ward had an infection control link nurse who was encouraging staff to undertake the screening.
- Infection control training compliance on Lion and Dolphin ward was 82%.
- We observed routine deep cleaning occurring on Lion and Dolphin ward.

Nursing Staffing

- Staff reported that there were sufficient nursing staff to ensure that shifts were filled in line with their agreed staffing numbers. Vacancy rates across paediatrics and the neonatal unit were minimal, with only one vacancy at present. Vacancies were held over the summer months as these were times of reduced activity on the inpatient paediatric wards. Staff we spoke with felt this system worked well, and did not leave them under-resourced during the summer months.
- Staffing levels on the paediatric units were such that there was always at least one nurse on duty who had completed the Emergency Paediatric Life Support course, and could therefore take the nursing lead in the event of a medical emergency.
- The paediatric High Dependency unit, which consisted of a four bedded bay plus one side room, was allocated two trained nurses per shift, one of whom had undertaken or was currently studying for the paediatric high dependency course.
- Sickness rates within paediatrics were currently 3.7%, and for the neonatal unit (NNU), 6%. This was higher than the trust sickness absence rate of 2.9%, but apart from the neonatal unit, below the England average. Staff told us that they felt this higher rate was as a result of long-term sickness. As a trust, results for the 2013 NHS Staff survey reported that less staff felt pressurised to attend work when unwell, (26%) compared with staff nationally (28%).
- Following a skill mix review in March 2014, using the Plymouth Staffing Tool for a 2 shift system, it was identified that the currently staffing levels on Buscot ward do not meet the requirements of the neonatal toolkit. This states that there should be a supernumerary member of staff in charge of each shift. This is currently only occurring during normal working hours. Whilst plans have been made to release some cost savings by changing the banding of some posts when staff leave, it is unclear how this shortfall in staffing is to be met.

- Nursing staff working in the community are lone workers. Staff reported having developed their own safety systems to ensure they are safe when working alone.

Medical Staffing

- All children were seen by a consultant within 24 hours of admission to the ward.
- Currently there is a single registrar providing cover between 10pm and 8am for both Lion and Dolphin ward and Buscot ward. This is identified in the neonatal toolkit as needing separate cover for paediatrics and neonates.
- 10 middle grade staff should be in post; however, senior medical staff told us that there was always at least one post vacant. This leads to consistent under filling of allocated Registrars/SHOs (senior house officers) on the rota, creating a shortfall that has to be covered internally or via locums. There is a recognised national shortage of middle grade doctors within paediatrics.
- Junior doctors told us that they felt supported. Consultants had a very low threshold to come back onto the ward to review their patients.
- Nurses told us that when they were concerned, they were also encouraged to call the consultant.
- Consultants undertook ward rounds daily, including at weekends.
- Medical staff reported being well supported, with speciality teaching appropriate and frequent, occurring on various days each week. This was in contrast to the GMC National training Scheme Survey 2013, which reported overall satisfaction, induction, workload, local teaching, feedback and study leave as worse than expected. As a result of the outcomes from this survey, the paediatric department had reviewed the findings, and were working on ways to address concerns, such as supporting GPs to manage children within the community, and additional registrar hours within the emergency department. This in turn was felt to be reducing workload, and thereby freeing up time for medical staff to attend training. One member of the junior medical team told us “this is the most training and support I’ve had, and it’s very thorough”. Within community paediatrics, training sessions occurred through clinic-based learning. Where clinics were held by trainees, these were observed, evidenced and feedback given to the trainee to support learning.

Nursing and Medical Handover

- Medical and nursing handovers took place at set times throughout the day.
- Nursing handovers occurred at each change of shift. Staff received an overview, and then had an individual and more detailed handover of care at the bedside. In addition, on the paediatric wards, the nurse in charge, who had the overall co-ordinating role, received a detailed handover from their counterpart, where additional high risk issues, such as staffing for the shift, was discussed, as well as any high risk patients or potential issues.
- There were three medical handovers per day, occurring at 8.30am, 4.30pm and 9pm.

Management of the deteriorating patient

- The paediatric department used the Paediatric Early Warning Scoring System (PEWS), whilst for those dealing with neonates the tool used was the Neonatal Early Warning Scoring system. There were clear directions for escalation printed and laminated within each child’s file on the wards. We spoke with staff, who were aware of the appropriate action to be taken if patients scored higher than expected.
- We reviewed notes and saw that where higher scores had been recorded, either action had been taken to escalate concerns, or the rationale for not escalating had been documented (for example, after a higher threshold for referral had been agreed).
- We saw that repeat observations were taken within the necessary time frames. Observation charts were clear to interpret and securely filed.
- Lion and Dolphin ward had a PEWS champion, with a remit to undertake a weekly audit on the use of and quality of completion of the PEWS charts. The results of these were a key performance indicator and were discussed monthly at the Urgent Care performance meeting.
- The hospital had an outreach service to support staff, and to provide care to patients in a deteriorating condition. This service operated 24 hours a day, seven days a week. All nurses who worked within the outreach service were trained in Emergency Paediatric Life Support. Nursing and medical staff we spoke with were aware of this service, how to access it and had found it to be both supportive and beneficial whenever used.
- Buscot ward was designated a level 2, local neonatal unit within the area. This requires any neonate born

under 27 weeks gestation, and those requiring a high level of intensive care such as cooling, to be transferred to a level 3 facility. Staff were aware of this, and processes were in place to facilitate the transfer of these babies safely across the network via the Southampton and Oxford Retrieval Team.

- The Southampton and Oxford Retrieval team also retrieve older children when required. Procedures were in place to ensure that these children were cared for safely and appropriately until retrieval occurred. Retrieval time was usually quick, but where there would be delay, the paediatric department had worked with the intensivists and anaesthetists to ensure that children could be safely cared for within the intensive care unit. Staff acknowledged that when this originally occurred, there had been concerns from staff within the intensive care unit. As a result, a debriefing session had been held, additional training had been provided, and paediatric emergency equipment was now stored within the intensive care unit.

Safety Thermometer

- The trust undertook the adult safety thermometer and applied it to paediatrics and neonates. Staff recognised this had limitations with regards to paediatric and neonatal care, but used it to record episodes of harm and hospital acquired infections.
- In February 2014, the paediatric wards reported that they had no pressure ulcers, urinary tract infections or falls with harm, and that care had been 100% harm free. These results were displayed on wards for staff, patients and visitors to see.

Incidents

- There had been no recent 'never events' reported within the directorate. There was one serious incident reported within the last six months. This was currently being investigated with a full root cause analysis by the ward sister, with the support of the unit matron.
- Following an initial review of the case, immediate changes had been put in place as a result of the serious incident. These included both a change in where a procedure was carried out and how the procedure was checked.
- Staff we spoke with were aware of the incident, and of the changes that had been made. Staff told us that family members had been notified of the error immediately, and there was a plan to share the report with them, should they wish.
- All staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system, and most had at some time in the past.
- Incidents were investigated by the ward sister / unit manager. Where necessary, issues were addressed with individual staff, for example, as a result of a drug error, and the learning from incidents was shared at ward meetings, emailed to staff, and minutes were produced for reference.
- We saw evidence that learning had occurred as a result of incidents. For example, as a result of one incident on the neonatal unit, procedures had been changed with regards to the administration of expressed breast milk.

Environment and Equipment

- The children's department and neonatal unit were secure areas. Areas were accessed through a locked door, controlled by a buzzer, with CCTV observation. Staff wore identification badges containing their photographs. We observed people being questioned before they were allowed entry.
- Equipment was appropriately checked and cleaned regularly. Labels were used to indicate when a piece of equipment had been cleaned and was ready to be reused. Clinical electronics staff had a room on Buscot ward, where regular maintenance and repairs were carried out. Staff here held an inventory of equipment in order to record what equipment was due a service, and when. Other maintenance was carried out through service level agreements with the manufacturer (for example, the new transport incubator).
- Staff told us that they had access to the right equipment when required, some of which they purchased through charitable funds and donations to the areas. Generally, staff felt that the trust would purchase what was required, but were aware they had access to charitable funds if funds were refused.
- Where cot sides were in use, risk assessments and the rationale for use were clearly documented on the risk assessment.
- Staff told us that reported faults often took some time before being rectified. On the paediatric ward, we saw that the assisted bath had been unable to be used since 23rd January 2014, when it was reported that it had a leak. A new part was ordered on 11th February 2014. At the time of the inspection, the assisted bath remained out of use.

- Medical gas supplies on the neonatal unit did not comply with national requirements. This required all intensive care and high dependency cot spaces to have two separate oxygen inlets. This had been identified as a significant risk and was recorded on the risk register. It is unclear from the risk register when this risk was identified. At the time of the inspection, work was underway to rectify this, and seven cot spaces were not in use whilst the work was underway.
- During the works to rectify the issue of inadequate medical gases on the neonatal ward, additional changes were being made to the layout of two nursery areas, which would mean nurses could communicate easier and the babies in one area could be cared for by one nurse without compromising their safety.
- The milk kitchen on Lion and Dolphin ward was not maintained at the correct temperature for the storage of milk. Whilst this had been identified on the risk register as requiring action to address, it was unclear what actions were to be taken or when, or how the risk was being managed in the interim.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked and records made.
- Rooms where medicines were stored were locked with keypads. On Buscot ward, two drug cupboards within this room were locked; however, keys were left hanging in the locks. This was visible from outside of the room. This meant that should the door be left unlocked, access to the contents of the cupboard was possible.
- Medicines reconciliation rounds occurred on both the childrens wards and on Buscot ward. Medicines were restocked through a 'top up' system, ensuring a continued supply.
- Out of hours, the hospital had an emergency medicines cupboard, and also access to an on-call pharmacist. Staff we spoke with described the access to out-of-hours pharmacist advice as good. They felt that when required, the out-of-hours pharmacist always attended.
- Ward rounds on Buscot ward were also accompanied by a pharmacist.
- In order to reduce the likelihood of administration errors on Buscot ward, all new nurse applicants were required to undertake a maths test with a requirement that they achieve 100%.
- As a direct result of a serious prescribing error, changes had been put in place, of which staff were aware.
- Oxygen therapy was not prescribed on the childrens ward. Prescription charts had a specific section for the prescription of oxygen; however, this was not filled in on one set of records that we looked at. We saw the patient was in receipt of oxygen therapy. Staff we spoke with said oxygen was never prescribed on the ward. However, when a child accessed the ward via the emergency department, oxygen was prescribed if commenced there.
- Staff were open and reported medication incidents. We saw evidence that these were investigated, and staff seen on an individual basis, during which they were asked to reflect on the incident. Where the incident was a prescribing error, we saw senior medical staff were informed and the error was followed up with the doctor concerned.

Records

- Patients were admitted and discharged electronically, and electronic discharge letters were produced. Other than that, all records were in paper format. Nursing records were kept separately to medical and other health care professionals generated documentation; however, we found records were sub-divided and it was easy to locate and follow information.
- When not in use records were stored in a trolley or on shelves near to or behind the nurses station.
- We saw there were five patients with temporary medical files on the one side of Lion and Dolphin ward, out of a total of 16 patients. Staff told us this was because they had not been able to access their main hospital records.
- Patients who were given an 'open door' invitation to attend had their notes held within the department, as these children attended frequently.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately and correctly. We saw examples of parental consent prior to care being administered.

Safeguarding children

- The Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in West Berkshire, undertaken by CQC in 2012 found the contribution of health to safeguarding children and young people to be good. Front-line staff

communicated well with young people and their families, and actively involved them in decisions about their care and support. The report found good support for teenagers who were pregnant, and for vulnerable women. This promoted their wellbeing and protected unborn and new born babies. During that review, safeguarding arrangements were sensitive to the diverse needs of all children, with tight scrutiny of risks to children with complex health needs or disabilities. We saw these processes had continued, with vulnerable women, and teenagers who were pregnant, being cared for by the Poppy team of midwives, who communicated closely with staff on Buscot ward. We saw a file was maintained to ensure that antenatal safeguarding concerns were notified to Buscot ward, in order that staff were prepared on delivery.

- The trust had a named safeguarding nurse and doctor. The safeguarding nurse attended the ward weekly and was available for advice and support at other times. Staff we spoke with were aware of how to raise safeguarding concerns. Compliance with safeguarding level 2 training was good, and the trust had a plan of how to progress staff to level 3.
- Multi-agency safeguarding meetings were held three times a year. In addition, a Child Protection peer review meeting occurred monthly, at which all complex child protection cases and recent evidence were discussed.

Mandatory Training

- We looked at staff mandatory training records. Training attendance was recorded on a large, easy to read chart on Buscot ward. This system was yet to be in place on Lion and Dolphin wards.
- Training records supplied by the trust were lower than those held within the departments. Staff explained this as being due to delays and inaccuracies in reconciling training on the electronic staff records, even when training had been undertaken online. At times, staff were required to take a screen shot of the completed online module to provide evidence that they had undertaken it.
- Nearly all staff had level 2 safeguarding training (92% on Buscot ward, and 94% on Lion and Dolphin ward) and were up to date with Paediatric Life Support (PLS). It was the intention that nursing staff working with babies and children undertook level 3 safeguarding training. This had commenced, initially with senior staff, with a plan for this to be further spread throughout the nursing team.
- Training figures on Lion and Dolphin ward showed that 82% of staff have had an appraisal.
- Since training compliance became linked to incremental uplifts, senior nursing staff told us that staff attended more readily.

Are services for children & young people effective?

(for example, treatment is effective)

Good

The Childrens and Young Peoples service was effective. Care and treatment was delivered in line with national guidelines. Outcomes were reviewed, and there was active participation in research and audit.

Care plans and pathways were in use, which meant that staff were provided with the instruction on how to care for specific conditions in line with national guidance.

Multidisciplinary team working was good in all areas, and transition planning occurred for some, though not all, chronic conditions. This meant that specialist input into all areas of care occurred.

Use of National Guidelines

- The Neonatal and Childrens areas used a combination of NICE, Royal College of Paediatrics and Child Health (RCPCH) guidelines to determine the treatment they provided. Local policies were written in line with these, and were updated if national guidance changed. Compliance against national guidelines was monitored at monthly governance meetings.
- We saw evidence that up-to-date practices were carried out, for example, checking the placement for a nasogastric tube prior to feeding on Lion and Dolphin ward.
- Guidelines are discussed and agreed at Procedure and Policy meetings. These were held monthly and alternated between paediatrics and neonates. This meeting then fed into the Neonatal and Paediatric Governance meeting.

- Specialist guidelines were written, discussed and ratified in conjunction with the various specialist services. For example, 'Safe Sedation Practice for Children' (Academy of Medical Royal Colleges) was referred and ratified by the Sedation Policy Group.
- Buscot ward was accredited UNICEF baby status level 3 (one level away from full accreditation). Baby Friendly awards are based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. At each stage they are externally assessed by UNICEF UK. All new staff attended a two day breastfeeding course run in conjunction with the midwifery service.
- Buscot ward parent support group funded National Childbirth Trust breastfeeding councillors to visit the ward twice a week to provide additional support to women breastfeeding their babies.

Outcomes for the unit

- Readmissions to the neonatal unit were recorded as significantly higher than expected. The trust had reviewed these and felt the figures were incorrect. When questioned, staff told us babies were, in effect, 'double counted' due to admission reports through two IT systems. The trust were still looking into the causes of this at the time of the inspection.
- Joint perinatal mortality and morbidity meetings were held with obstetricians and midwives, and were open for all staff to attend.
- Participation occurred in a wide range of national audits and research programmes, such as Epilepsy12, the SIFT research project which reviewed feeding in neonates, and PLANET 2, a platelets study. Research programmes were supported by three research nurses who were based on Buscot ward.
- Local audits took place and were monitored through governance meetings. For example, a recent audit into the use of the correct pathway for MRI was undertaken which reported 100% compliance with the performa.

Care Plans and Pathway

- Patient records contained clear plans and objectives. There was evidence within the notes that care was evaluated, and objectives were reviewed and changes made accordingly; for example, when increasing feeds on Buscot ward.
- Where parents were to be taught to carry out care, we saw plans were clear, detailing how they were to be taught the skill and have their competency to carry out the task checked.
- Care pathways existed for some conditions, such as febrile neutropaenia, and for surgical admissions into Kempton day bed unit.

Multidisciplinary Team working

- Weekly ophthalmology assessments were undertaken on Buscot ward for Retinopathy of Prematurity screening. The booking system to ensure that all babies were seen appropriately was managed efficiently by the ward clerks. Staff reported no concerns in how this system was managed.
- The child protection lead nurse attended both Buscot ward and Lion and Dolphin ward weekly. Formal meetings were held weekly on Buscot ward to ensure that staff were aware of current and upcoming issues.
- Pharmacists attended both Buscot ward and Lion and Dolphin ward daily. On Buscot ward pharmacists were part of the daily ward round team for all neonates.
- Buscot ward had a bereavement link nurse who worked in close contact with the bereavement midwife. This ensured there were links with the children's hospice and end of life consultant. Where required, the end of life consultant visited parents and babies on Buscot ward to develop and implement a plan of care. This provides support to both staff and parents.
- Planning for transition to adult serves for children with epilepsy or learning disabilities commenced when the child became 13 years of age. Planning involved the adult nurse specialists, adult physicians, paediatricians, the child and their parents. The process was less structured for children with other chronic healthcare needs, such as those with cystic fibrosis.
- The risk register contained evidence of insufficient physiotherapy time to meet cystic fibrosis quality standards and general paediatric needs. Actions to address this were not clear.
- Children admitted electively to Lion and Dolphin ward under a specialist consultant (for example, children

undergoing orthopaedic surgery) were admitted under the care of that specialist team. At times, advice and support was requested from paediatricians. Staff reported this could cause delay in accessing treatment. Children admitted as emergencies were admitted under the care of paediatricians. The process for accessing medical advice and support in these cases was clearer.

- The trust provides shared care for oncology patients. A clinical nurse specialist is employed, and weekly multidisciplinary team meetings are held. Consultants from Oxford attend monthly to review treatment plans in conjunction with the local team. Guidelines and policies, such as those for the management of febrile neutropaenia and chicken pox, were developed through collaborative working.
- Lion and Dolphin ward had paediatric physiotherapists and occupational therapists. In addition, there was a dedicated pharmacist who attended, Monday-Friday.

Are services for children & young people caring?

Good

The Childrens and Young Peoples service was caring. Staff provided care in a kind and compassionate manner. Parents were involved in both decision-making and the delivery of care. Patients, parents and staff were provided with appropriate emotional support. At times of bereavement, parents were provided with advice and support in a sensitive way.

Compassionate Care

- Throughout our inspection we witnessed babies, children and their parents being treated with compassion, dignity and respect.
- Both parents were encouraged and involved in the care of their babies and children.
- We saw that call bells were answered promptly. Parents we spoke to described staff as kind, caring, friendly and supportive.
- Parents were encouraged to visit and spend as long as they wanted with their child.

Patients involvement in their care

- Children and parents we spoke with felt that they had been involved in their care and decisions around their treatment.
- We saw evidence that parents were updated daily on their baby's condition on Buscot ward. Skin to skin contact (kangaroo care) was encouraged daily on Buscot ward.
- When a child was being discharged in receipt of nasogastric feeds, we saw evidence that parents received structured teaching and an assessment of their competency in the procedure. Parents were then encouraged to continue to administer all nasogastric feeds whilst the child remained an inpatient, in order that their practice could be further monitored. Signed records were maintained to demonstrate this process had been successfully completed before discharge.
- Parents spoke of feeling included in decision-making processes and were aware of the treatment options available. On Buscot ward, we saw evidence that parents were updated daily.

Emotional Support

- Following the death of a child on the ward a debriefing session was always available for the staff involved and those who had formed a relationship with the child. Occupational health referral was available for staff if required.
- Bereavement midwives were employed. Buscot ward had a link nurse who liaised closely with the bereavement midwives to ensure support and advice for both staff and parents.
- Hospice nurses had close links with Lion and Dolphin ward. During our inspection we saw them visit a child on the ward who had been an inpatient for some time.
- There was a specialist child psychologist to support families and children. Staff also had access to a psychologist if required.
- Buscot ward held an annual service of remembrance for bereaved parents. This allowed parents and staff to remember the babies that had died on the ward in a formal and supportive way.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Good

Services for children & young people

Good

The Childrens and Young peoples service was responsive to the needs of the population. Processes were in place to ensure the flow of patients through the departments went well. Staff worked with GPs and health visitors to attempt to reduce the need for hospital admission. Electronic discharge letters were produced in a timely manner to ensure appropriate care continued in the primary setting. Satellite pharmacy services prevented delays in discharges.

The service was designed to meet the needs of all children. Support was available for children with learning disabilities or long-term physical needs. Interpretation services were available if required. Close links had been made to ensure communication processes were good with the Alexander Devine Children's Hospice.

Maintaining flow through the department

- Children were either admitted directly to the ward or through attendance at the emergency department. If seen in the emergency department, and it was unclear if admission would be required or not, children were transferred to the paediatric short stay unit, opposite Lion and Dolphin ward. Here, under a period of prolonged observation, they could await test results until a decision was made to either admit or discharge. This area was open and staffed from 12 noon to midnight by a registered nurse (child) and a play therapist. Staff reported some confusion with regards to medical responsibility for decisions when children were in this area. On occasion, this had led to delay in discharge as emergency department doctors felt they had discharged the child, but they had not been admitted under the care of a paediatrician.
- In order to reduce unnecessary admissions, medical staff had begun working with GPs to provide education and support to facilitate care in the community, as opposed to hospital admissions for some cases. These were supported by fully developed clinical pathways.
- The department had worked with the pharmacy department to develop a 'satellite pharmacy'. Some medicines to take home were stored and dispensed directly from the ward by the ward pharmacist, to reduce delays in discharging children home.
- There were clear escalation plans for when the wards were busy.
- Nurse-led constipation clinics were held to reduce waiting times. Consultants, as well as GPs, referred children to this service.

Meeting the needs of all children

- Support was available for patients with learning disabilities or physical needs. Community paediatricians undertook shifts within the hospital to address issues, and provide continuity of care for those children who were inpatients.
- A translation telephone service was available 24/7 and interpreters could be booked in advance for face-to-face consultations. Some leaflets were available in alternative languages, although not all.
- There were multiple information leaflets available for many different complaints and conditions. These were available in the wards and departments, and were also available on the hospital website. Children who had been admitted to the ward following an episode of deliberate self harm could only be assessed by the Child and Adolescent Mental Health Services (CAMHS) teams between Monday and Friday. Children with complex mental health needs would often remain on the ward beyond the acute phase of their condition whilst an appropriate bed was identified in a specialist unit. This had been raised as an issue on several occasions with the Clinical Commissioning Group. Whilst these children remained on Lion and Dolphin ward, one-to-one support and care was provided by the trust if the need was identified. Where required, staff told us this would often be provided by agency nurses trained in mental health.
- Transition arrangements for adolescents existed for children with learning disabilities and epilepsy. However, formal transitional arrangements did not exist for all chronic conditions, such as cystic fibrosis.
- A team of children's nurses provide support to parents caring for a wide range of complex healthcare needs in the home setting.
- The trust hosts one of the Alexander Devine Children's Hospice charity nurses to provide respite services. These nurses have close links with the ward, providing additional support and advice whilst their child was on the ward.
- Schooling is provided at the bedside Monday–Friday mornings in term time.

Good

Services for children & young people

Environment

- Storage areas were clear, clutter-free and well labelled, ensuring staff were able to access equipment quickly.
- Parent information was widely available and displayed within the ward and parent areas.
- The ward areas were bright and attractively decorated for children.
- Lion and Dolphin ward had a play area, which was well stocked with a variety of toys and activities to suit all ages. There was also a separate play area for the use of children on the Kempton day bed unit, and those attending the paediatric short stay unit.
- There was a variety of accommodation for parents. On Buscot ward, two rooms were used as 'flats' where parents could stay and have their baby with them as discharge approached. On Lion and Dolphin ward, parents were encouraged to stay. There were fold-up beds for parents to sleep at their childs bedside, and both areas had facilities for parents to access food and drinks. Lion and Dolphin ward also had two rooms that were used for oncology patients. These had a separate bedroom/living area adjacent, to allow parents to stay with their child.
- Environmental changes were in progress on Buscot ward as a result of medical gas works. The removal of a wall would mean a greater degree of visibility for babies within that area.

Communication with GPs and other departments within the trust

- A discharge summary is sent to the GP by email automatically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken. The speed in which this process occurred had been improved following work by medical staff. As a result of identified delays, a proforma had been developed and a clerk employed to type the electronic discharge letter. As a result, letters were often prepared for when the child left the ward, meaning parents could take their own copy. In the event that discharge occurred before the letters could be checked by the discharging doctor and signed, a letter was sent to the childs home.
- Surgical and orthopaedic teams undertook daily ward rounds on Lion and Dolphin ward. Staff stated that it was not difficult to get advice from other specialities within the trust, although at times there was a delay in their attendance. In an emergency, support was always available from the paediatricians.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were encouraged to speak to the senior nurse on duty. If they preferred, they were directed to the Patient Advice and Liaison Service (PALS).
- The matron for the paediatric and neonatal unit received all complaints relevant for her unit. She would then speak directly with the staff member involved to provide a response. Where possible, a meeting was offered. Where complaints involved several departments, these were all brought together and the final response shared with contributors. Complaints, and the outcome of the investigations, were a regular agenda item at ward meetings, as well as at the paediatric and neonatal governance meeting.

Are services for children & young people well-led?

Good

The Childrens and Young Peoples service was well-led. There was a highly visible leadership team. Staff were aware who the senior nursing and medical team were within their speciality; however, fewer staff were aware of the structure and content of the senior leadership team.

The culture was found to be open and supportive. Staff were aware of the whistleblowing policy and were encouraged to use it. Incidents were openly reported and staff felt that they reported incidents to identify why they happened, rather than to apportion blame.

The governance processes within the service were structured and clear. Feedback occurred to staff from within the speciality and also across the organisation.

The services appeared to strive for improvement and learning, as incidents, complaints and concerns were shared across teams.

Good

Services for children & young people

Leadership of service

- Nursing staff on all areas were led by a single matron who visited each area regularly throughout the day. During both the announced and unannounced inspections, we saw the matron on Lion and Dolphin ward and also on Buscot ward. Each area then had a ward manager / sister responsible for the day-to-day management of that area.
- Three consultants were designated as lead consultants within the service; one for neonates, one for paediatrics and one for community paediatrics and neurodisabilities. All met weekly with their consultant colleagues.
- Staff were aware who their senior nursing and medical team were, and felt they promoted the service, their issues, risks and clinical requirements well within the organisation.
- Most senior nurses were aware of the leadership structure above the Urgent Care Network; however this was less well known amongst more junior staff.

Culture within the service

- Staff were aware of the whistleblowing policy and were encouraged to raise any concerns they may have.
- Staff reported feeling well supported and valued within their roles by their managers and their team members. Within Lion and Dolphin ward, staff were able to nominate an employee of the month. This was publicised on a notice board, with the winning nominee identified and the reasons for their nomination explained.
- Staff worked well together and there was obvious respect between, not only the specialities, but across disciplines.
- Staff spoke positively about the service they provided for the babies, children and their parents. Many had been employed at the trust for a large number of years.
- Service level staff survey data was not available, but overall the trust performed well in regard to staff feeling satisfied with their work, effective team working, being able to contribute towards improvements at work and better communication between staff and senior managers.

Vision and strategy for this service

- The department vision was visible throughout the wards and corridors. Most senior staff were aware of the trust vision, though this was less well known amongst more junior nursing and medical staff.

Governance, risk assessment and quality measurement

- Monthly governance meetings were held for paediatrics and neonates. Complaints, incidents, audits, quality improvement projects and compliance with national guidance were discussed, as well as key performance indicators. Minutes were taken and placed on a shared drive for all staff to access. Pertinent points were fed back to staff at ward and department meetings.
- The paediatric unit and Buscot ward held their own risk registers, which were discussed at the monthly governance meeting. Staff we spoke with were aware of the more significant risks these contained.
- Both perinatal and paediatric mortality and morbidity meetings were held monthly.
- Procedure and policy meetings were held monthly, alternating between paediatrics and neonates. Here new guidelines were discussed, and existing guidelines revised. Ratification of these then occurred at the governance meeting.
- Child protection peer review meetings were held monthly, at which all complex child protection cases and recent evidence were discussed.
- The service is not yet conducting the Friends and Family Test.

Innovation, learning and improvement

- Children admitted through the day bed unit, who required dental treatment for dental caries, were discharged home with a toothbrush and toothpaste.
- The practice development nurse on Buscot ward ran an 'academic surgery' once a month, which enabled staff to attend and discuss their future academic needs.
- As a result of a complaint, midwives had been trained to administer intravenous antibiotics to babies who required it whilst on the postnatal wards. Prior to this change, mothers had to bring their babies to Buscot ward at 2am and 2pm for their intravenous therapy. All mothers were requested to attend at that time, and as a result they often had to wait standing in the corridor. Following the training, mothers and babies were able to remain on the postnatal ward.
- Four pathways were developed and agreed for use by GPs: bronchiolitis, fever, gastroenteritis and limping. In 2013 these were updated in line with national guidance. Following this, update and education sessions for GPs and health visitors were underway.

Good

End of life care

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

Information about the service

The Royal Berkshire Hospital had a palliative care (PC) team that demonstrated a high level of specialist knowledge, service delivery and strategic planning. The PC team comprises of a nurse consultant, a part time medical consultant, clinical nurse specialists, a palliative care nurse, occupational therapists and a part time social worker, clinical psychologists and a team administrator. The PC team were available 7 days a week,Monday to Friday 8.30-4.30pm and Saturday and Sunday 9-5pm.Outside these hours the PC service was covered by the hospice.

During our visit we spoke with members of the palliative care and bereavement teams, the porters, chaplain and staff on the wards. In the last six months a total of 734 patients have died in the hospital, of which 329 patients were known to the Palliative Team. The rest of the patients were supported by EOL care on each ward.

We visited a variety of wards across the trust, including Adelaide, Castle, Victoria, Emmer Green, Sidmouth, Hunter and Whitley wards, the Chemotherapy day unit and outpatients, bereavement office, hospital mortuary and hospital chapel. We reviewed the medical records of patients at the end of life, and observed the care provided by medical and nursing staff on the wards, and spoke with six patients receiving end of life care and their relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

Summary of findings

The PC team available seven days per week, with the hospice providing out of hours cover. Medicines were provided in line with guidelines for EOL care. DNACPR forms were not consistently completed in accordance with policy and there were not standardised processes for completion of MCA assessments.

Training relating to EOL care was provided at induction and study days were arranged for palliative care link nurses from wards. Leadership of the PC team was good and quality and patient experience was seen as a priority.

All patients requiring EOL care could access the PC team. Viewing times in the mortuary were limited, which impacted on patients families being able to view their relative. There was a multidisciplinary team (MDT) approach was in place to facilitate the rapid discharge of patients to their preferred place of care.

Relatives of patients receiving EOL care were provided with meal vouchers and free car parking. Patients were cared for with dignity and respect and received compassionate care. The ‘End of Life Care Plan’ was the pathway patients were placed on in the last few days of life.

Good

End of life care

Are end of life care services safe?

Good

There was a multidisciplinary PC team available seven days per week, with the hospice providing support out of hours. EOL care on the wards was provided by the ward staff who reported they were able to provide EOL care, with six nurses recently recruited with experience in EOL care. Medicines were provided in line with guidelines for EOL care. Use of both EPR and paper based records meant records could be fragmented at times. Training relating to EOL care was provided at induction and study days were arranged for palliative care link nurses on the wards.

Cleanliness, Infection control and hygiene

- Overall the standards of cleanliness and hygiene on the wards we visited were good.
- We saw that the wards, day units and mortuary viewing area we visited were clean, bright and well maintained.
- We saw that throughout the clinical areas visited that the general and clinical waste bins were covered and that appropriate signage was used.
- We saw that ward and departmental staff wore clean uniforms with arms bare below the elbow and that personal protective equipment (PPE) was available for use by staff in all clinical areas.

Staffing

- The PC team comprises of a nurse consultant, a part time medical consultant, 4.4 whole time equivalent clinical nurse specialists, one full time palliative care nurse (plus one on secondment), 1.7 occupational therapists (plus one on secondment) and a part time social worker, clinical psychologists and a team administrator.
- The PC team were available 7 days a week, Monday to Friday 8.30-4.30pm and Saturday and Sunday 9-5pm. Outside these hours the service was covered by the hospice.
- During our inspection we asked ward managers about their staffing levels and whether they had enough staff when they had to manage EOL patients.
- On Whitley Ward we were told by the ward manager that the ward establishment had increased following a dependency tool pilot. We were told that in the absence of the directorate matron, the process of gaining approval to bring in agency staff was slow.
- On Castle Ward they were not staffed to establishment but felt that staffing levels were adequate and they can employ agency staff when required.
- Six new RN's had been employed on Emmer Green Ward since the beginning of the year. The RN's had worked previously in the community and were trained in EOL care. Only one vacancy exists at present.

Incidents

- During our inspection we visited Sidmouth ward where a 'never event' was reported in November 2013 relating to a patient receiving EOL care. We spoke to the charge nurse. The 'never event' involved the insertion of a naso-gastric (NG) feeding tube and led to a full root cause analysis investigation, the results of which were relayed back to the staff. The charge nurse told us that lessons had been learnt. Staff completed a re-training session. Policy has been updated, and following all insertions of NG feeding tubes, an X-ray needs to be performed prior to the feed being attached.
- On Adelaide ward the ward manager told us that incidents were reported to the matron and entered on the online reporting system, Datix. We were given an example where an incident had to be reported when a patient in their EOL care developed a pressure ulcer. A root cause analysis investigation was performed. The learning from the incident was reported back to staff and a teaching session was arranged on the ward by the Tissue Viability Team. All staff attended the session. A new pressure care pathway was introduced onto the ward as a result of this incident.
- We found that systems were in place to learn from incidents. We were told by staff that discussions would take place at ward meetings, and training sessions would be arranged including aspects relating to EOL care.

Medicines

- The Berkshire Adult Palliative Care Guidelines – EOL care – GL110, comprehensively sets out the medication for patients receiving EOL care. We noted that the policy was written in 2013 and was due for review next year.
- We were told by the ward managers on Whitley and Adelaide wards and on the stroke unit that medication

for EOL care was available on the wards and was easily accessible. The ward manager on Whitley ward was confident in the ability of the nursing staff to care well for EOL patients with syringe drivers, with support from the PC Team.

- The PC Team has three non-medical prescribers, plus one member of staff currently on the course.
- On the wards, staff told us that the PC team nurse prescribers "will mostly advise on medication but at the weekends would prescribe medication".
- On Emmer Green ward we were told that the PC team will advise on the medication for syringe drivers. We observed a syringe driver checklist alongside the medication prescription chart. Staff were knowledgeable about the need to review medication every few days.
- The PC team told us that McKinley syringe driver training had been implemented across the medical wards by both the PC nurses and the practice education leads. Information would be cascaded to the palliative care link nurses to support staff in their area.
- On Mortimer ward we saw that pharmacy checks are performed daily. For the last three months pharmacists have been taking part in the ward rounds.

Records

- Across the wards we visited we found evidence that both electronic patient records (EPR) and paper medical records were in use. This meant that patient's medical and nursing histories were fragmented and difficult to follow.
- The PC team told us that the patients they reviewed have a further set of medical records. The PC team place a red sticker on the Royal Berkshire medical records to inform ward staff that PC records exist. The PC records contained information such as the preferred place of care and death, holistic needs assessment tool and a care plan of identified needs.
- On Heygroves and Trueta wards we saw that nursing records, input from allied health professionals (AHP's) and ward round notes, were entered in the EPR and the doctors would input into the paper records. This was evident on Emmer Green ward where we found no universal documentation format from ward to ward. Medical records were confusing to wade through. Staff told us that advanced discharge plans were on EPR and not on the paper records, but on reviewing medical records on Emma Green Ward, we did find that an occupational therapist had written in the paper records along with the discharge plan form. This meant that poor record keeping placed patient's safety at risk.
- We saw that the hospital had a resuscitation policy which was available to all staff. Staff we spoke to were knowledgeable about the policy.
- The PC team told us that the Clinical Commissioning Group (CCG) had a Commissioning for Quality and Innovation (CQUIN) in place around the completion of DNACPR forms.
- While visiting the ward areas, we randomly checked 10 medical records containing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.
- We saw that all decisions were recorded on a standard purple form. The DNACPR form was at the front of the notes, allowing easy access in an emergency.
- We saw that there were variations in the completeness of the forms across the hospital: All but one was signed by a consultant, none had a review date.
- The ward manager on Heygroves and Trueta wards told us that after admitting a patient, DNACPR's would be raised 48 hours after the patient's medical situation was clear. Registrars on the ward round usually complete the form.
- We saw evidence in two patient's medical records of completed DNACPR forms which had come in with the patients and were kept with the patients as they moved round the system. No review date was evident in either form.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- We were told by the PC team that Mental Capacity Act (MCA) assessment forms are available on the hospital intranet. On admission a 'mini assessment' would be completed by the admitting doctor and a best interests decision would be made. We were told that the hospital has an older person's mental health liaison team who keep very clear notes on patient's mental health status; however, we could not confirm this as we did not meet with this team during our visit.

Training

- Staff employed at the Cancer Centre, will have the Cancer Centre orientation pack emailed to them on their first day on the ward, and this will contain oncological policies and procedures. We were shown

the Adelaide ward departmental orientation pack, which contained information such as staff development, safety in the workplace, information and communication systems, and an introduction to cancer nursing.

- The PC team told us that they are actively involved in the training of staff during the induction programme. This was confirmed by a staff nurse on Emmer Green ward, who had received EOL training by the PC team and was able to describe what the training entailed.
- We were told by the PC team that their role included training core teams of staff on the principles of EOL care. This would include multidisciplinary team training, medical (FY1 and 2) specialists, consultants and oncologists. This was confirmed when we spoke to a junior doctor on Whitley ward, who told us that they had received EOL and palliative care training during the induction, plus an extra three sessions from the PC team, which they described as “very helpful”. This covered symptom management, holistic treatment and end of life care. Two other junior doctors told us that the "training was much better than they had received at other hospitals".
- We met with the practice education lead, for the Planned Care Group, who explained to us about the EOL training and how it is part of the hospital induction process. Study days are arranged for palliative link nurses on the wards, who will then cascade the information down to staff on the front line. We were told that 'Sage and Time' communication workshops are arranged by a member of the PC team, where staff are involved in role play and get experience of difficult situations. We were told by a nurse on Adelaide ward that they had undertaken this training.
- The practice education lead described to us that across cancer services a training needs analysis is performed to establish the training required to meet the changing service needs. We saw the training matrix and observed that courses for the registered nurses (RN) were planned over a two to three year period, in order to ensure that everyone was able to attend. We saw that registered nurses had enrolled themselves on courses over the time period of the training matrix, and that registered nurses on Adelaide ward had to attend a basic cancer module, which included pathway and multidisciplinary team working. Staff were therefore supported to enable them to deliver care and treatment to patients to the appropriate standard.
- We saw the training matrix for the clinical nurse specialists (CNS) in which all were expected to study for a postgraduate certificate in Cancer Nursing at the Oxford Brooks University. This course will be funded in part by the hospital and charity funds. Looking through the training matrix we could see that all the CNS’s were registered on the course and were all at different stages of completion.
- The porters team leaders told us that two mandatory training days had been organised for March 2014. These training days would include resuscitation, adult and child safeguarding, fire, infection control, manual handling and mortuary training. We saw that the majority of portering staff were signed up to complete mandatory training on these days.
- Mortuary staff told us that mandatory training was up to date and was undertaken online or by attending clinical days. We saw evidence that staff had attended courses, such as a cosmetic camouflage make up course. This showed that staff were being supported to develop their skills and become part of a more flexible, skilled workforce.
- We were told by the heart failure nurse that colleagues were attending a course to learn about 'Caring Together'. A project developed by the British Heart Foundation and Marie Curie to improve care at end stage heart failure. This shows that staff are developing their skills to improve the quality of care they deliver to their patients.

Are end of life care services effective?
(for example, treatment is effective)

Good

The PC team was introduced as a consequence of the NICE quality standards relating to EOL care and the team based their care on these standards. The PC provided evidence based advice to other professionals as required.

The ‘End of Life Care Plan’ was the pathway patients were placed on in the last few days of life, which had been designed by the PC team following the decision to stop using the Liverpool Care pathway.

MDT working was good and the geriatricians on one ward demonstrate good practice with medical advanced plans in place for patients requiring EOL care.

Good

End of life care

Use of National Guidelines

- The Royal Berkshire Hospital had implemented National Institute for Health and Care Excellence's (NICE) quality standards for improving supportive and palliative care for adults, with the introduction of a palliative care (PC) team that demonstrated a high level of specialist knowledge, service delivery and strategic planning, and provided wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life.
- We saw evidence across all the wards and departments we visited that the PC team supported and provided evidence-based advice to other health and social care professionals (for example, on complex symptom control), by undertaking training (for example, medication training for junior doctors and the development of policy to guide staff nursing EOL patients).
- The palliative care team based the care they provided on the NICE Quality Standard 13 – End of Life Care for Adults, by introducing systems that enhanced the quality of life for people with long-term conditions, ensuring that people have a positive experience of (health) care, and treating and caring for people in a safe environment and protecting them from avoidable harm. The PC team benchmark their services against this standard at the EOL governance meeting, but we were told this is not formally reviewed annually.
- A recent release from the Leadership Alliance for the Care of the Dying included a statement (March 2014) to confirm that there will not be a national tool to replace the Liverpool Care Pathway (LCP). The PC nurse consultant told us that a timeline was being prepared for the Chief Executive, around the development and implementation of the replacement care plan, including guidance for staff and an educational programme.
- Any changes in their EOL care plan will be implemented through an educational programme via the practice education leads, link nurses on the wards, a medical training programme and targeting local governance meetings.

Outcomes for the unit

- The hospital contributed to a local bereavement survey, the results of which are sent to the specific ward areas if any issues are found, where the ward manager will take the lead. The findings of the survey will be discussed at the EOL governance meeting to ensure that issues are acted on. Overall the data was very positive.

Care Plans and Pathway

- We spoke to the PC nurse consultant who told us that a modified version of the Liverpool Care Pathway (LCP) had been used to support EOL patients. After guidance from the Department of Health (October, 2013) the LCP has to be phased out by trusts by July 2014. An amended version has been developed by the PC team, called the 'End of life Care Plan' which patients are commenced onto in the last few days of life by a consultant, following discussion with the patient/family and multidisciplinary team. When we spoke with the PC team, staff confirmed that the trust was continuing to use its own amended version of the LCP for EOL care. Staff would seek verbal consent from patients or families before moving a patient onto the EOL care plan. This showed that the trust had responded to concerns regarding the LCP, and had developed an amended version to ensure a safe approach to care.
- We saw on Hunter ward that a laminated copy of the EOL care plan was available for the staff to follow.
- We were told by the PC team that as part of their role, they had developed EOL and palliative care processes and procedures, such as a concise guide to breaking bad news, development of a medical advanced plan, and an advanced care plan, to ensure that patients quality of life was enhanced as they moved towards EOL care.
- We saw evidence of the medical advanced plans on Whitley and Hunter ward and Emmer Green ward where selected treatments would be administered. This meant that patients had clear medical decisions made in a timely manner, ensuring that inappropriate care would not be delivered.
- On Castle ward, we spoke to a registered nurse who told us that they had two patients on EOL care. Patients would be offered a side room if they preferred, and the EOL care plan would be commenced after discussions with the multidisciplinary team, patients and relatives. We were told that it was similar to the LCP, but more selective in its use and that registered nurses often had to instigate the use of medical advanced plans for deteriorating patients.

Good

End of life care

- Following referral, patients on the EOL care plan were reassessed on a regular basis by the PC team, to ensure the EOL care plan remained appropriate for them.
- We spoke to a junior doctor on Whitley ward who was able to give a good clear understanding of the issues around EOL care, and was able to access the PC team guidelines on the hospital intranet, along with a good understanding about the need for advanced care plans (ACP). However, we were told that there is not much evidence of ACP beginning on the wards or training in, and understanding of the Mental Capacity Act (2005).
- On visiting Dorrell ward, we were told by the acting ward manager that patients can be admitted from Accident and Emergency into a side room for EOL care. We were told that the ward staff were familiar with the EOL care plan and feel "well supported by the PC team". The nursing staff rely on medical teams to make treatment decisions, but feel competent to talk to family and manage patients.
- During our visit to Accident and Emergency (A&E) we were told by staff of links with the PC team to provide emotional and practical support for relatives and staff who suffer and experience a sudden death. For patients who wish to be cared for at home, the PC team will facilitate a fast-track discharge process. A&E staff highlighted the difficulties of trying to discharge patients during the weekend.
- On visiting the Intensive Care Unit (ICU) we saw that comprehensive systems and processes were in place to support patients requiring EOL care, including 'the withdrawing of treatment protocol'. Staff could tell us about the protocols they followed. The PC team told us that EOL care is well managed in ICU, and families and staff are supported by the ICU bereavement team. However, we did note that the working policies required reviewing and updating to meet 2014 professional guidelines.
- The bereavement team carried out the administration of a deceased patient's documents and belongings, providing practical advice, and signposting relatives to support services, such as funeral directors. The office was open limited hours, Monday to Friday, 8.30am to 2.30pm. This means relatives can be denied access to the service and suffer unnecessary waits to receive death certificates.
- We spoke with the porters about the arrangements for transporting patients to the mortuary. We were told that porters had received training by the mortuary staff to ensure that they were able to carry out the necessary procedures in the mortuary at weekends and overnight. The porters we spoke to could tell us about the protocol they followed.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. A confidential letter box is available to secure the patients paperwork. We observed that the book was completed appropriately and neatly, and was completed in a respectful way. Confidentiality was maintained at all times.
- A new training update for the porters had been arranged by the porter's team leader. This was confirmed when we visited the mortuary and saw that the relevant documentation for the training was in place.
- This indicated that staff received regular updates, and staff told us that when transporting children to the mortuary two team leaders would undertake this duty, and articulated that children are treated with the utmost dignity and respect. The maternity porter would be supported by a member of the labour ward staff.
- The bereavement officer worked closely and effectively with the coroner's office and helped advise junior doctors of the correct procedures after a death.

Multidisciplinary Team working

- We saw evidence across the wards of multidisciplinary team meetings, to discuss and guide staff on patient management issues.
- On Kennett ward we spoke to the ward manager who told us that a multidisciplinary team ward round is undertaken with the geriatrician, and that good systems were in place for the discharge of patients with the development of medical advanced plans, so providing good practice in the care of patients at EOL.
- A junior doctor on Emmer Green ward told us that a multidisciplinary team meeting takes place every morning to discuss issues such as patient's mental capacity, and relatives are involved in these discussions early on in the EOLC pathway.
- On Castle ward the consultant undertakes a ward round three times a week and on a Saturday and Sunday, with good multi-professional working. The registered nurse felt confident in challenging doctors about the decisions that were made regarding EOLC pathways.

Good

End of life care

- On Emmer Green ward they have a strategy to cover EOL and palliative care teaching for registered nurses. A rolling programme of training has been developed by the practice educator and PC team. Link nurses for palliative and dementia care link with new initiatives, and cascade the information down to ward staff. However, we were unable to locate the log of training on the ward to demonstrate this.
- Within ICU we were told that clinical governance meetings take place, where doctors present cases to staff. At the February meeting, sudden death and organ donation were discussed. As a result, staff placed organ donation information in the room set aside for relatives, which we confirmed when we visited the relative's room.
- The PC team told us that seamless working is in place alongside other specialities, including the pain team, the acute oncology team and the older people's mental health liaison team. We observed this during the inspection, as we saw how the teams linked together to ensure seamless care.

Seven day services

- We were told by the PC team that systems were in place (such as shift patterns and on-call rotas) to provide timely PC and advice, at any time of day or night, for people approaching the end of life, or receiving palliative care who might benefit from specialist input.
- Patients could be referred to the PC team via telephone or the hospital management system, seven days per week 8.30am–4.30pm Monday to Friday, and 9-5pm Saturday and Sunday. Families could ask to see the team via the ward staff. Relatives told us that the PC nurse was always available when they asked.
- Out of hours, the Sue Ryder hospice would give advice and support. Initially, a nurse will receive the call; however, if they are unable to help, the first doctor on-call or consultant on-call will be contacted. This meant that EOL patients had access to specialist skills to support their palliative needs. Staff on the wards told us that they felt confident in the support mechanisms in place for EOL patients.
- The Department of Spiritual Healthcare (Chaplaincy) are available seven days a week, 9-5pm, as well as advertising an urgent number which can be used to contact the chaplaincy after 5pm. Information was available on the hospital website detailing how to contact the chaplaincy. The information booklet 'Here to Help' is easy to read and lists the spiritual services that are available within hospital throughout the week.

Are end of life care services caring?

Good

Patients were cared for with dignity and respect and received compassionate care. Feedback from patient and relatives was positive stating they felt fully informed and involved in their treatment and care. Medical and nursing staff were seen to be compassionate and caring involving patients and their friends and families.

Compassionate Care

- On visiting the stroke unit we spoke to a family about the EOL care that their relative was receiving. The family told us the staff were "very helpful and compassionate" and that "all the staff seemed familiar with the care needs of their loved one".
- We were told by relatives on the stroke unit that normal visiting times were waived and that they were able to visit at any time. This was reflected in other wards across the hospital including Adelaide ward.
- On Adelaide ward, a relative of a patient on EOL care explained to us that when their relative was admitted to the ward they were greeted by the nurse in a very caring manner, with physical contact that made a huge difference to their relative. The family felt that their relative was cared for well "both physically and emotionally and was treated as an individual by staff".
- On Whitley ward we observed that staff were welcoming and polite with relatives. A patient receiving EOL care was being nursed on the ward. We observed that five members of the family were round the bed and that a baby had been brought in to see their great grandparent. This showed that staff were meeting the needs of both the patient and family by being sensitive and compassionate.
- We visited a patient on EOL care on Heygroves and Trueta wards. The patient explained to us that the "nurses were marvellous, very attentive and responsive" and are "always there if you need anything".

Good

End of life care

Patient and family involvement in Care

- One family on the stroke unit explained to us that they felt fully involved in the relatives care and felt able to ask questions. The family believe “staff and doctors explain themselves and give skilled, attentive and compassionate care”. We were told that the PC team have been in constant touch, and information has been given regarding ongoing support. We were given an example where the wishes of the patients were observed by the nursing and medical team, and that “staff ensured all members of the family were comfortable“ with the wishes of their relative.
- On Adelaide ward a family told us that the doctors gave the family good explanations about their relatives EOL care. We were given an example by the family which showed that the staff were always involving the family when their relatives conditioned changed. The family felt they had been kept “fully informed with clarity and sincerity”.
- A patient receiving EOL care on Heygroves and Trueta wards told us that the "medical staff were good and visited frequently and the clinical nurse specialist was involved and came to chat". We were told that on Thursday there was a multidisciplinary team meeting and that they were "waiting for the results" to find out what was going to happen next. The patient felt involved in their care.
- The ward manager on Mortimer ward told us that "consultants are good at communicating with the patients and family" and identifying when further active treatment is not benefiting the patient. Enhanced pathway for all admissions and discharge planning starts early with the family. We were told that the senior nurse runs a ‘visitors clinic' weekly. Appointments are made for structured times with relatives to keep them informed and up to date with their relatives care.

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

(for example, to feedback?)

Outstanding ☆

All patients requiring EOL care could access the PC team, with nearly 40% of referrals not relating to patients with cancer. The team received 1230 referrals in 2012/13 and aimed to review all urgent referrals within 24 hours. The PC team felt staff on ICU and elderly care wards manage EOL care for rapidly deteriorating patient effectively.

Viewing times in the mortuary were limited which impacted on patients families being able to view their relative. MDT approach was in place to facilitate the rapid discharge of patients to their preferred place of care, although this can be complex with patients living with dementia on an EOL care pathway.

Relatives of patients receiving EOL care were provided with meal vouchers and free car parking. There were facilities for relatives available on wards. There was a bereavement service on ICU who completed a patient diary for the relatives to keep.

Access

- All patients within the trust, requiring palliative or EOL care have access to the PC team, seven days a week. We were told by the PC team that nearly 40% of referrals are non-cancer related. Relatives on Castle ward confirmed that “the PC team have made themselves available seven days a week to them”.
- Urgent advice is available from the clinical nurse specialist (CNS) who can give telephone advice prior to reviewing the patient.
- The team aim to review the patients within 24 hours. This was confirmed by staff on Whitley ward, who reiterated to us the availability and effectiveness of the PC team.
- We were told by the PC team that non urgent referrals, including non-urgent discharges and advice, will be seen within 72 hours, excluding the weekend. The PC team told us that in 2012/13 the team received 1,230 referrals.
- In the first six months of 2013/14 (September-February 2014), the team were referred 329 patients, which is 40% of the total deaths in the trust. We spoke to the PC team, and the patients not referred were those patients who deteriorate rapidly throughout the evening and night, those cared for on the ICU where good EOL care is delivered, and elderly care who manage deteriorating patients effectively.
- A palliative care medical consultants post is shared with the Sue Ryder hospice. We were told that this role supports patients on the ward with complex symptoms,

supports junior doctors on Adelaide ward, and is leading on an initiative called 'making every moment count', which includes tunnelled drains and electronic discharge letters.

- We were told by the bereavement officer that when they are absent the role will be performed by mortuary staff, which may result in delays for relatives and doctors, as their availability must be managed alongside their substantive role.
- We visited the mortuary viewing suite where families can come and spend time with their relatives. One hour appointments can be organised through the bereavement office between 9am and 2pm Monday to Friday. The limited viewing times may prevent family from viewing their relatives, and we heard from our listening event that this had occurred.

Discharge arrangements

- Systems are in place to facilitate the rapid discharge of patients to their preferred place of care. The PC nurse explained that a multi-professional approach is in place, which includes an occupational therapist, to secure rapid discharges to the preferred place of care.
- We were given an example of where a patient on ICU was discharged within hours to their preferred place of care, and they were able to spend nine days with their family. We were told that generally the process can take up to three days. No audits were available.
- However, on Emmer Green ward we were told that patients living with dementia who are receiving EOL care need their care tailored to their individual needs. This requires lots of liaising and frustrations around waiting for care to be in place when patients are ready to go home. We were told by staff that time differs per locality.

Meeting the needs of all people

- On the ICU we were told that a bereavement support team are available, to support families whose relatives are in ICU and are receiving EOL care, along with any staff members that require support whilst nursing an EOL patient. The team provide training for new staff within ICU. The team link in with the PC team with regard to complex patients who want to be cared for at home, but problems arise when discharges cannot be arranged over the weekend.
- The work of the bereavement team in ICU was explained to us. We were given an example where the team developed a patients 'experience diary' to give to the relative, to show how the staff had supported the patient during their time in ICU. This was a great help to the family.
- The PC team have developed information leaflets for families whose relatives are receiving EOL care. The information available includes 'the hospital Palliative Team', 'No decision about me without me' and 'Information for relatives and friends of someone who is dying'. On speaking to relatives we were told they had received the information which they found helpful.
- The Sanctuary is a multi-faith room that is available for all to use, and is described as a place for 'peace and reflection'. Both Muslim and Christian services are performed in the Sanctuary throughout the week. We saw that a booklet was available to signpost patients and relatives.
- We spoke to the chaplain who told us that there was a named chaplain for each world faith.
- An Islamic Iman is available 24/7 and we were told that Muslims use the Sanctuary daily for prayers.
- Stillborn care is carried out in Christian traditions, but this has now been adopted by the Iman. This shows that the needs of different religions are being developed.
- The PC team distribute 'comfort bags' for patients and relatives of EOL patients. These bags have been provided by a charity, and allow relatives to freshen up during their stay in hospital while staying with their EOL relative. This shows that the needs of relatives are being supported during their stay.
- Relatives visiting the bereavement office or coming to view their relative will have to walk along a corridor that was in the process of being replaced, which was unsightly. The work is due to be finished in April 2014.
- We were told by staff that they would like to walk relatives from the main reception area, but due to staffing constraints this service cannot be provided; therefore, at present, relatives have to make the journey on their own. We noted that the mortuary is signposted on the hospital map.
- Systems were in place to support staff who experience sudden deaths. Debriefings take place with senior staff within 24 hours, and the chaplain, if requested, is present. Further support is available through occupational health and the Employee's Assistance Programme.

Good

End of life care

Facilities for relatives

- We were told by the PC team that car parking and meal vouchers are given to relatives when patients are on EOL care. This was confirmed by families on the stroke unit, and Adelaide ward, who had received free car-parking and meal vouchers.
- The mortuary has a viewing suite where families can come and visit their relatives. We visited the area and saw that the viewing suite was divided into a reception and a viewing room which had recently been refurnished.
- The suite was clean, fresh and modern, and provided facilities for relatives such as comfortable seating, water fridge, tissues and information booklets about bereavement. The suite was neutral with no religious symbols, which allow the suite to accommodate all religions. We were told by the mortuary manager that relatives will be supported by staff and will ensure that relatives know what to expect and are safe.
- The mortuary manager told us that they accommodate all faiths and gave an example of where they supported a viewing with 150 visitors. This shows that the staff are sympathetic to other cultures and will accommodate requests.
- On our visit to the mortuary we were shown where deceased patients leave the hospital, with the undertaker or with family. We found the area to be a loading bay where supplies come and go from the hospital, which did not provide a safe and respectful area for families to receive their relatives.
- We visited Castle, Victoria, Mortimer and Adelaide wards to see the relative facilities. In Castle ward there was a 'quiet room' with four chairs, where relatives could relax when anxious, upset or needing time to reflect, but one relative told us that the facilities for staying overnight were poor. In Adelaide ward staff ensured that refreshments and breakfast were supplied to relatives in the quiet room. We observed that the room had two comfortable sofas, TV with video, and an exercise bicycle.
- In Mortimer ward the relatives had a bright open area, with comfortable chairs and a visual stimulation machine with different coloured lighting. We were told that there were no reclining chairs or sofa bed available for relatives who wished to stay by their relative's bedside.
- We observed that reclining chairs were available, along with a camp bed, for relatives who wished to stay by their relative's bedside on both Castle and Adelaide wards.
- In Victoria ward we were told that the quiet room was shared with three other wards, and only normal chairs were available when relatives wished to stay by their relative's bedside. Three side rooms are available for EOL patients who wish for privacy during their time in hospital.
- The Accident and Emergency Department had its own relative's room which was situated close to the resuscitation and majors area. The room was clean and tidy with a neutral decor. Tea and coffee facilities were available for relatives. Organ donation information was seen on the notice board, and bereavement leaflets were on the table for reference.

Are end of life care services well-led?

Good

Leadership of the PC team was good, with good team working; although there were varying views regarding the importance of EOL care at board level. Quality and patient experience was seen as a priority with staff feedback about the service being positive.

There were regular team meetings where performance data, complaints and incidents were discussed. The PC nurse consultant gave examples of practice that the team were proud of, which included being fully compliant with the cancer peer review standards (quality assurance programme), providing a holistic approach to patients receiving palliative or EOL care, the development of a medical advanced plan with the palliative consultant and comprehensive weekly multidisciplinary team meetings.

Leadership of service

- There was good leadership of the PC team led by the nurse consultant. One consultant commented that "they didn't feel that EOL care was high on the Continuing Professional Development (CPD) list but access to the PC team gave him confidence".

Good

End of life care

- We found little evidence of what happens above the PC team around the trusts strategy concerning EOL care. Continuous restructuring of the executive team meant there was no consistent leadership or board representation for EOL care.
- However, we were told by one member of staff, "Personally, I feel the board is committed to EOL care, it's a priority".
- Ward staff generally felt well supported by their managers and told us they could raise concerns with them; this was particularly evident across the cancer services, where both in- and outpatient managers felt well supported by the matron. However, one member of staff did feel unsupported due to their role being more than anticipated, and felt that there was no one to go to if stressed.
- Staff felt disconnected from the board, and felt that there was no connection between front-line staff and the trust's senior managers. Medical and nursing staff did not feel their concerns were acknowledged or addressed by management.

Culture within the service

- All the staff we spoke to, spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility, and this was very evident in both the PC team and the dementia care team through their patient-centred approach to care.
- We found that staff had a 'can-do attitude'; which meant that the staff were very patient-centred and wanted to deliver good care through good training and support. The practice educators we met were very proactive in their approach to developing the workforce, and ensuring the training of staff fitted the changing needs of the patients.
- Across the wards we visited we saw that the PC team worked well together with nursing and medical staff, and there was obvious respect between, not only the specialities, but across disciplines. The PC team were complimentary of the EOL care that the ICU and elderly care delivered.
- One consultant told us that it was "an utterly friendly trust – I feel very welcome".
- The charge nurse on Sidmouth ward told us it was a busy ward, but that the staff "were very committed and will go the extra mile".

Vision and strategy for this service

- The palliative care nurse consultant told us that the trusts vision around EOL care was to prepare patients for EOL care, and facilitate preferred priorities of care (PPC) and preferred place of death (PPD).
- There was a desire to make appropriate and timely decisions around when active treatment goes to palliative care.
- Networking, with other providers, community and GPs for better care closer to home, was a priority.
- We were told by a consultant that an area for improvement in EOL care would be communication. This requires "dialogue with busy consultants and time is needed with relatives". This will be a major piece of work and will require working alongside patients and relatives.

Governance, risk management and quality measurement

- We found that the PC team and the Adelaide ward held regular team meetings in which performance issues, concerns, complaints and general communications were discussed. Staff who were unable to attend were emailed the necessary information.
- The chemotherapy day manager told us that a team brief take place every two weeks. A planned care sisters meeting takes place monthly, where complaints, incidents, audits and quality improvement projects were discussed. We were told that support is available from both the lead nurse and the divisional nurse.
- Risks were regularly identified and flagged on risk registers, both at ward level and at divisional level.

Innovation, learning and improvement

- The PC nurse consultant gave examples of practice that the team were proud of, which included being fully compliant with the cancer peer review standards (quality assurance programme), providing a holistic approach to patients receiving palliative or EOL care, the development of a medical advanced plan with the palliative consultant (that we saw was being used on the wards we visited), comprehensive weekly multidisciplinary team meetings, and the development of clear processes for the discharge of patients from ICU, including ventilated patients.

Requires improvement

Outpatients

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

Information about the service

The Royal Berkshire Hospital NHS Foundation Trust has outpatients departments at the main site in Reading at the Royal Berkshire Hospital, West Berkshire Hospital in Thatcham, and Townlands Hospital in Henley. There are specialist outpatients clinics held at other locations such as for Ophthalmology at the Prince Charles Eye Unit in Windsor and audiology, cancer services and dialysis at the Clinic in Bracknell. We visited the outpatients departments at the Royal Berkshire Hospital and West Berkshire Hospital.

At both sites we visited there were main outpatient departments, where clinics were held at least five days per week. At the Royal Berkshire Hospital there were outpatient clinics for services such as dermatology, rheumatology, general medicine and general surgery, and specialist clinics providing services such as opthalmology, orthotics, ear, nose and throat (ENT), and cardiology. Some of the specialist clinics were located adjacent to the specialist wards and departments, and some were in separate buildings located around the main hospital site. At West Berkshire Hospital, the outpatient departments provided clinics which included audiology, dermatology, cardiology, ear, nose and throat, neurology and ophthalmology. There were fewer outpatients clinics provided at Townlands Hospital, and these included paediatrics, renal medicine, ophthalmology, dermatology and ear, nose and throat.

During our inspection, we visited the main outpatients departments at the Royal Berkshire Hospital and West Berkshire Hospital. At the Royal Berkshire Hospital we visited specialist clinics for cardiology, orthotics, ENT, orthopeadic, eye clinic, diabetes and endochrinology, and pain clinics. At West Berkshire the clinics operating in the main outpatients during our visit included ENT, rheumatology and neurology. At both hospitals we talked with receptionists, medical secretaries, medical records staff, administration business managers, the matron for outpatients, lead nurses, health care assistants, consultants, patients and family members. We observed waiting areas and clinics in operation. At the Royal Berkshire Hospital we visited the X-ray and pathology departments. We received comments from our public listening event and reviewed other performance information provided by the trust.

Requires improvement

Outpatients

Summary of findings

Patients received kind and compassionate care and were treated with dignity and repsect with their privacy maintained. Patients told us that staff were kind and they felt involved in their care. There were one stop clinics and specialist clinics provided.

Medical records being available at all clinics for each patient was not consitently achieved due to notes 'missing'. Staff shortages in clinics and administration staff reaulted in long waiting times for patients. In addition, delays in radiology significantly impacted on the efficiency of the outpatient service. There was a significant variation in the time between outpatient consultation and the GP receiving the outcome letter from within one week to six weeks.

There was also a lack of information in any alternative language or format other than in English. The outpatient department staff felt supported and learning was communicated from incidents and complaints.

Are outpatients services safe?

Requires improvement

The individual outpatients departments we visited varied in the level of safety they provided for patients. The risks identified in the majority of the clinics we visited at the Royal Berkshire Hospital were: missing patient notes, the maintenance of patient notes, lack of staff, time lapse between consultation and the GP receiving the outcome letter and a lack of knowledge of the whistleblowing procedure by staff from all grades.

The issues with patient notes put patients at risk, due to potentially having a consultation without the doctor having all the information they required available. The lack of staff meant that patients had to wait longer than the accepted period to obtain an appointment, which could result in a delay in diagnosis and treatment. Staff not being aware of the whistleblowing procedure could put vulnerable people at risk, due to a lack of reporting of concerns.

We found individual service managers had introduced practices to improve the safety of services in their own department. These included regular clinical governance meetings, where learnings from incidents were shared, the introduction of volunteers to assist patients journey through that specific clinic, and the completion of quality audits, followed by the sharing of action plans. Whilst these measures went some way to improve the safety of the service in that particular area, there was no recognition of the issues by the trust's executive board, and no action plan in place to make trust-wide improvements in outpatient departments.

Cleanliness, Infection control and hygiene

- Clinical areas we visited appeared clean, and we saw staff regularly washed their hands and used hand gel between treating patients. Patients were also encouraged to use the hand gel provided before their consultation.
- 'Bare below the elbow' policies were adhered to by all staff in the clinic areas.
- Toilet facilities and waiting areas were clean in all areas we visited.
- Personal protective equipment (PPE), such as gloves, aprons and eye protection, was available for staff use in all necessary areas.

Requires improvement

Outpatients

Staffing

- We were told there was a lack of administrative staff in some clinic departments, such as ophthalmology, and this meant there could be a wait of up to six weeks before a letter was sent to a GP following consultation. This delay meant that patients were not assured that their GP would receive information in a timely way, and this could cause deterioration in their condition. Administration staff attributed this to there being no cover for sickness or holidays, and increased workload due to managing the letters from community clinics.
- Medical secretaries also told us they took all the telephone calls for the doctors they were working for, and this could add to their workload. An example of this was forty messages waiting for one secretary following one day of annual leave.
- Some areas, for example, the eye clinic and orthopaedic clinic, had a shortage of reception staff. We saw that this resulted in patients queuing for up to fifteen minutes to register on arrival at one clinic. At one time there were eleven people standing, waiting to register in the eye clinic. We were told the administration staff came from the office to assist; however, this then meant that they became even more delayed with their own work.
- Some staff told us that there were long waits in the clinics due to staff shortages, such as specialist consultants. In most departments, a business case had been made to the trust in order to fill vacant posts.
- The waiting times for 'choose and book' appointments varied between departments. Some, such as orthopaedics, had a wait time of 4.6 weeks with 92% of new patients seen within six weeks. Other specialities, ophthalmology for example, had a longer waiting time of 10.2 weeks with 43% of new patients being seen within six weeks. The long wait for the first appointments in some departments, was discussed by patients at the public listening event.
- We were told there were shortages of staff in several departments, including the main X-ray department in the Royal Berkshire Hospital. When we visited, there were four agency staff on duty, and we were told the department “could not run without them”. We were that told agency staff were being used until the summer, when a cohort of newly qualified radiographers would be recruited. These agency staff received an induction into the department when they worked there.
- The outpatients’ pathology laboratory had two areas, but staff told us they could only open the second area for testing if they had sufficient staff, which required two phlebotomists. We saw that it was opened on one day to reduce the waiting time for patients at the main pathology laboratory. Staff said that patients could wait up to ninety minutes at peak times, to have their blood tests taken. Staff liked to keep the wait to no more than thirty minutes. This meant that at times patients were waiting three times longer than the departments own informal target, due to lack of staff.
- In some departments, we were told retention of staff was difficult. Reasons given for this were excessive workload and the proximity to London, without London weighting being included in the salary.

Incidents

- There had been no recent 'never events' reported in outpatients or radiology.
- All staff we spoke with stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at weekly department meetings and staff were able to give us examples of where practice had changed as a result of incident reporting. One example of this was the removal of wheels from chairs in the waiting room at West Berkshire Hospital, following a patient incident caused by them.
- Staff we spoke with at both hospitals, including administration and clinical staff, had little knowledge of the whistleblowing procedure. Whilst some staff told us they knew they could “look it up on the intranet”, others said they had “heard of it” and one staff member said “I’ve seen something about it on the television”. They did tell us they would report anything they were concerned about to their line manager. This meant staff, of all levels, were not aware of the correct procedure for reporting concerns.

Environment and Equipment

- The environment in the outpatient areas was safe. Some areas, such as the paediatric audiology clinic, were in need of updating. An example of this was the insulation to ensure that the areas for hearing tests were adequately soundproof to complete the tests successfully. These areas were included in the hospital’s environmental improvement programme.
- There were space constraints in some clinics, such as the eye clinic, due to the amount of equipment required and the layout of the department rooms. Equipment for

vision tests was only accessible in the consultation rooms which, when in use, led to delays in some clinics, due to lack of room availability to carry out vision tests prior to consultation.

- Equipment was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas. In some clinics, staff told us the equipment was outdated, and this included the main X-ray department at the Royal Berkshire Hospital, where some of the equipment was over twelve years old. One new piece of diagnostic equipment was being replaced during the inspection. The remaining outdated equipment was on the risk register.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary.
- Patients told us they received adequate information regarding new or changed medication, and written information was given. Staff told us that this written information was available in English only, and in no other format. This could mean patients for whom English is not their first language, or who have difficulty with the written word, may not understand medication directions.
- One patient told us they had been able to discuss changing their medication with the doctor they had seen at the clinic, and felt they had been listened to.

Records

- Staff at the Royal Berkshire Hospital told us that they were often missing some notes for each clinic. We saw this varied, with one clinic of 203 patients having 20 patients' notes missing, and a clinic of 100 patients having seven sets of notes missing, whilst staff in another department said they had "on average one set of notes missing per clinic each day".
- For those patients who may be seen without a full set of notes, we saw, and were told, that a temporary record would be made, and the least information the consulting doctor would receive would be the referral letter, if it was a new patient. These referral letters could be retrieved from the electronic patient record system. A doctor who saw a patient without a full set of notes would not have all the information they required to ensure the patients safety. Details such as allergies and past medical history may not be known by the consulting physician.
- One lead nurse at West Berkshire Hospital had highlighted on the risk register, as an 'amber risk', the issue with notes not being returned from clinics to medical records quickly enough. This was not included in the clinical governance report for March 2014.
- We saw that there was a person employed, in the medical records department, whose job it was to locate missing notes. This showed some measures had been taken to resolve the problem; however, notes continued to be missing from outpatient clinics.
- Staff said there were different filing systems between the Royal Berkshire Hospital and West Berkshire Hospital. This meant that there was a lack of consistency of where information was stored in patients' notes, making it difficult to locate specific items.
- Not all systems were incorporated onto the electronic patient records system, such as the X-ray department at the Royal Berkshire Hospital. Some surgical procedures had not been installed into the system for recording. This meant that there were two different recording systems employed in some departments; therefore the sharing of information could not be assured.
- There were comments, both favourable and otherwise, regarding the electronic patient records system. Some staff members said they found it a very useful tool, whilst others felt it was not helpful. Administration staff at West Berkshire Hospital told us the system "kept crashing" which made it difficult to use. Staff also told us there had been a lack of staff training and support for successfully using it on a daily basis. Staff also reported that when it was first installed, incorrect letters regarding clinic appointments were sent out, and this caused patients to be recorded as 'did not attend' when actually they had been given an incorrect appointment. We were told this issue had been resolved. We found individuals were using the parts of the system which they understood. This resulted in a lack of consistency with record keeping, which could lead to staff not being able to access the information they need to deliver safe care.
- Staff at the Royal Berkshire Hospital we spoke with were unaware if there was any audit of missing notes for the outpatient clinics they served. Therefore, the reasons for these missing notes were not being identified or rectified.
- At West Berkshire Hospital staff reported they did not have missing notes often and saw that all notes were available on the day we visited. We were told that a daily

audit of missing notes was completed to understand the problem and make improvements. They said the issues were mainly with notes coming from the Royal Berkshire Hospital or the off-site storage unit. These issues were fed back to the medical records department at the Royal Berkshire Hospital. There was no action plan in place to resolve this issue.

- A senior administrator at West Berkshire Hospital told us they attended a weekly administrators meeting; however, they felt this was weighted to the issues at the Royal Berkshire Hospital, and so did not address their issues to improve the service.
- Some of the patient notes we saw were in a poor state of repair, with ripped outer file jackets. One receptionist told us "notes can be loose in the files and fall out".
- We saw that some patients had multiple files of notes, and all of these were sent to the outpatients' clinic. We were told these notes, some of which were contained in a box of their own, were then moved around the department until they were returned to medical records. This resulted in excessive amounts of notes being stored in places such as medical secretary's rooms, whilst they completed their work.
- We were told that due to their records being missing, one person had waited nine months for a removal of a mole. This could have put this patient at risk of their condition deteriorating due to the wait.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately and correctly.

Mandatory Training

- Staff told us they received mandatory training, which they described as "very good" and "useful".
- Some staff we spoke with said they had not received health and safety training.
- They described the system of training as sometimes difficult to access, due to getting time away from their duties to attend. Staff at West Berkshire Hospital told us they had to attend training at the Royal Berkshire Hospital, which had the potential to increase poor attendance on training courses for those staff.
- Reception staff told us they received training which had an emphasis on safeguarding, and dignity and respect. They were aware of the need to be vigilant to signs of abuse, and some told us how they had received training in customer care. This showed there was an understanding of the need to train reception staff to develop their skills and attitude when dealing with patients. However, this was not consistent in all the clinics we visited.
- Several staff members, from various staff groups, told us that the managers had recently been encouraging them to attend the mandatory training to ensure they were up to date.
- We were told by staff that there were good opportunities to undertake additional training, which would add to the quality of care for patients. There was the possibility of funding this from the central training fund and the charity fund.
- At West Berkshire Hospital optometrists were accessing additional training from another speciality provider. This was a ten-week programme which covered a wide area of knowledge. This demonstrated a willingness to provide additional specialist training to assist staff to carry out their duties.

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

Not sufficient evidence to rate

Data on performance showed that the Royal Berkshire Hospital outpatient services were very busy in comparison to national averages. There were also a higher number of cancellations, with a large rise between May and August 2012, which remained higher than the national average. Staff we spoke with were unaware of why this cancellation rate was high, what it was attributed to, and any actions being taken to address it. Staff in individual outpatient areas were not aware that their own clinic cancellations were high. Some staff we spoke with stated that the individual outpatient areas functioned independently of the larger organisation.

There were some examples where breaches in waiting times had occurred. This included diagnostic CT, where there were 190 breaches in February 2014. MRI waiting times were breached 398 times in January 2014, and 500 times in February 2014. There was no action plan in place to address this issue.

We were given information regarding a project undertaken by an external company, which was completed in July 2013, in order to assess the service delivered by outpatients

at the Royal Berkshire Hospital, and to make suggestions for changes to improve the service. The recommendations of this project, with regard to increasing efficiency and so to improve the patient experience, continued after the poject completed.

One stop clinics

- One-stop clinics were in place for dermatology at both the Royal Berkshire Hospital and West Berkshire Hospital. This included such services as mole removal, where patients received a head-to-toe examination and had any tests such as a biopsy completed within the one clinic appointment.
- The trust also provided other one stop clinics including Rapid access breast biopsy and lower urinary tract symptoms.
- At both hospitals there was a drop-in service in the audiology department for a hearing aid clinic. Patients told us they liked this, as they could decide if they needed to attend or not. At West Berkshire Hospital one person told us they had waited two hours; however, they were aware this might be the case and did not mind.

Multidisciplinary or Specialist nurse clinics

- There was evidence of some multidisciplinary working in the clinics. This included physiotherapists being part of the fracture and orthotics clinics.
- At West Berkshire Hospital there was a multidisciplinary approach to managing bariatric patients. This included a specialist nurse, doctor and dietician, consulting with the patient at one appointment.
- One of the outpatient matrons had trained to practice acupuncture in the pain clinic, to supplement the practice of the doctors in the clinic.

Use of National Guidelines

- We were told guidelines, such as NICE guidelines, were followed where appropriate.
- The ENT and ophthalmology clinic followed the current best practice guidance for cleansing of all their equipment.

Availability of urgent / next day clinics

- Staff in the pathology laboratory told us that, depending on the test requested, some results could be reported to the GP within twenty four hours.
- Staff in the pathology laboratory described the procedure for patients to have their blood tests completed urgently if they were sent to the laboratory by staff at the clinic. They could process the results within 30 minutes for some tests and others within the hour.
- One main outpatient department receptionist told us that, depending on the clinic running, urgent appointments would be added onto the end of the clinic.
- There was an ophthalmology casualty clinic for which people could self-refer. One patient told us they had used this service several times, and found it to be very efficient.

Seven day services

- The X-ray department at the Royal Berkshire Hospital offered a walk-in GP service, where patients had three months from the referral to attend for their X-ray. They had sufficient resources to be able to offer a five day service for appointments, which meant patients did not have to wait unnecessarily to have their X-ray.
- One senior member of staff at the Royal Berkshire Hospital told us they had done some Saturday morning clinics, in the main outpatients, which had been very popular with patients. They told us they had no non-attendance when they ran these clinics. The lead of another clinic had submitted a business case for extended opening hours of 7pm to 10pm five days per week, and weekend services to be provided. However, there was no consistency across all the outpatient departments, with some people telling us they had done some Saturday clinics, but only to reduce a backlog and prevent the risk of breaching the waiting time limits. One person told us that it had been challenging to gain the support of the senior executives to approve plans for a mobile diagnostic screening facility, which would support the need for income generation, as well as reduce the waiting times. This prevented improvements in efficiency.
- At West Berkshire Hospital a manager told us that a trial had been carried out with early morning appointments, and these had been very popular with patients. There had been an issue with staff resources for these, and the effects on staff, of working outside their usual hours, was not recognised or appreciated by the hospital management.

Are outpatients services caring?

Requires improvement

Outpatients

Good

We found the outpatient services in both the Royal Berkshire Hospital and the West Berkshire Hospital were focused on the patients. We observed caring attitudes towards patients, staff were kind and the privacy and dignity of patients was protected. Patients we spoke with said the staff were "very good", "very caring" and polite. We saw staff had an understanding of how carers or relatives could be involved in a person's appointment, if both parties chose this.

Compassionate Care

- Staff in some individual clinics, such as outpatients one and two, told us they had carried out their own survey of patients. The lead nurses for these clinics, orthopaedics, cancer care and ophthalmology, organised an evening event. Forty patients had attended and provided feedback on a variety of aspects of the service. As a result of this, an action plan was drawn up and sent to each attendee. Actions from this included extended opening times and investigating the possibility of introducing technology such as Skype to reduce the need for visits to the hospital.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. This included reception staff being polite, explaining if there was a waiting time. The nurses and healthcare assistants called for patients in the waiting room in a dignified way; they greeted them, introduced themselves by name, apologised if there had been a delay, and took them where they needed to go.
- Patients told us staff were "friendly", "really good" and one person said "it's a great service". One person at West Berkshire Hospital, who attended outpatients regularly, told us staff were "reassuring" and they felt "well looked after".
- The environment in the reception area of the outpatient department did not allow for confidential conversations. In the orthopaedic outpatients department at the Royal Berkshire Hospital the waiting area was situated in a link corridor. Staff in all clinics we visited were sensitive to the lack of confidentiality, and stated they would be as discreet as possible, and if the patient wished, or there was particularly sensitive information to discuss, they would use a quiet room to do this.
- There were notices displayed to explain that chaperones could be provided if required. We saw patients' relatives or carers could accompany them into the clinic, if both parties chose this.

Patient involvement in care

- Patients we spoke with stated they felt that they were involved in their care. One patient in the eye clinic at the Royal Berkshire Hospital told us that although they were a "regular visitor" they always had time to ask questions and they got answers.
- One patient at West Berkshire Hospital told us they were "kept involved and informed" in their care, and another said the doctors and nurses spoke to them "like an intelligent human being". Another, at the Royal Berkshire Hospital, told us how they had been able to request changes in their medication, to reduce side effects, and this had been carried out.
- At West Berkshire Hospital there was a patient panel, which met every six months to feedback on the service they received, and discussed any ideas they had for improvement. It was reported that the Trustees were visible at West Berkshire and they had an office there. They had visited the department and spoken to patients about the service delivered.
- A medical secretary told us they got to know regular patients, and would try to help them get advice over the phone, or a quicker appointment, if they thought they were anxious about any aspect of their care.

Emotional Support

- Staff we asked told us they could give patients a quiet place and time following their appointment if they had received bad news.
- At West Berkshire Hospital we saw a member of staff sit with a patient and carer who had received bad news.
- We saw there were some notices and leaflets in the clinic areas at the Royal Berkshire, which provided helpline numbers and support networks for specific disease areas, such as mouth cancer in the maxillo-facial clinic.

Are outpatients services responsive to people's needs?

Requires improvement

Outpatients

(for example, to feedback?)

Requires improvement

When we spoke with staff in the various outpatient clinics, both at the Royal Berkshire Hospital and West Berkshire Hospital, there were some good examples of where services had been responsive to patients and the general needs of the service. These included increased numbers of clinics, extended opening hours for clinics, and increased staff numbers to reduce waiting lists. We did find that these changes were sporadic, largely temporary, and dependent on the individual staff members in the clinic, and were not a trust-wide initiative in response to service demand.

There was some feedback from patients regarding long waiting lists and long waiting times in the clinics. The trust provided some of this information, such as an 18 week waiting time for a follow-up appointment for rheumatology; however, staff we spoke with were not aware of an overall plan to reduce these waiting times. There had been an outpatient project commissioned and completed in July 2013 by a consultant company. The objectives of this had been to "improve patient experience in outpatient clinics by reducing waiting lists and delays in clinics", to "train a team of Trust employees and empower them to deliver part of the project" and to realise cost savings as a mixture of increased activity and reduced costs. Senior staff at both sites were aware of this project, and reported that "nothing has happened" following the completion of it. However, trust wide plans showed improvements were continuing.

At the Royal Berkshire Hospital there was a lack of adequate signage, both within the outpatient areas and in the corridors within the hospital. Patients, staff and volunteers told us this resulted in people finding it difficult to move from one area to another easily, such as from a clinic to the X-ray department. There was no signage or information in another language other than English, or in any other format than the written word. This could exclude some patients from accessing the information available.

Key responsiveness facts and figures

- The corresponding figures for the percentage of cancellations that were patient cancellations, or DNAs, dropped sharply between June 2012 and August 2012, from 100% to 60%. This indicates the increase in total cancellations, between those dates, was due to hospital cancelled appointments.
- The average waiting time in weeks for follow up appointments at all clinics ranged from six weeks to 23 weeks. Where the wait was high, there was no action plan in place to reduce it. For example, ophthalmology had a wait of 11 weeks, and we were told there were sometimes clinics on a Saturday but this "tends to be reactive".
- At both hospitals there were notices in the waiting areas which gave patients information regarding which doctors were in the clinics and the waiting time. Some clinics, such as the ENT clinic at the Royal Berkshire Hospital, had long waiting times of up to one hour displayed. One patient told us they had waited two hours. The waiting times appeared to be increased where there was a concurrent casualty clinic running, such as in ENT and the eye clinic. At West Berkshire Hospital the waiting times in the main outpatient clinics were seen to be less than those at the Royal Berkshire Hospital. There was no mechanism for sharing good practice between the two sites, and staff were unaware of any planned action to manage and reduce the waiting times. Some staff told us these long waits were due to staff shortages, such as specialist consultants. In most departments, a business case had been made to the trust in order to fill vacant posts.
- Some staff we spoke with told us that the length of the appointment slot may be causing the waiting times to be high, such as if the slot was not long enough and the next patient had arrived. We found the time given for consultation varied between the clinics, and was from five minutes to fifteen minutes. Some clinics had longer slots for new patients, who may have more questions, whilst others did not. There was no sharing of information between the clinics to ensure the optimum time was given to allow for a thorough consultation and reduce waiting times.
- The senior staff in some clinics, such as orthotics, had reduced the waiting times. In this clinic, they had reduced waiting times from 37 weeks to six weeks. This was due to a variety of measures, initiated by the lead of the service, which included not booking routine

follow-up appointments where there was no clinical need. However, there were unfilled staff vacancies in this clinic, and it was feared continued vacant posts could again increase the waiting time.

Ensuring attendance

- The initial letters sent out to patients were clear, and included all the information they would need inorder to attend their appointment, including maps. One patient reported the letter and any instructions as "very clear".
- Patients we spoke with at West Berkshire Hospital were happy with the directions and ease of attending the outpatients department. Those who visited the Royal Berkshire Hospital said they found car parking "very difficult". We saw that one patient phoned the reception desk to report that they were late for their appointment, but were not able to find anywhere to park. This was a theme which was also raised by many people at the public listening event.
- The staff we spoke with at the Royal Berkshire Hospital were unable to tell us how the patients who did not attend their appointments were managed. There was no clear policy in any clinic, where we spoke with administration staff, of how they dealt with these patients. At West Berkshire Hospital we were told there was no formalised protocol for the management of patients who did not attend. We were told, by a senior staff member, that if the appointment had been for something urgent, the consultant would be informed immediately, and the person contacted the same day. We saw this took place in the breast cancer clinic. In one clinic at the Royal Berkshire Hospital, where 19 patients were booked in, five patients did not attend. One of these patients was a two-week wait cancer referral. The lack of formalised follow-up could mean patients, whose health could deteriorate if they do not receive their consultation or treatment, may not receive a repeat appointment, or that it may not be in a timely manner.
- Text message and telephone call reminders had recently been started for some clinics. The staff we spoke with were not aware if patients for all clinics now received these. This could mean that some clinic DNA rates may improve through the use of text reminders; however, not all clinics will share this learning.
- Patients told us that they received written information regarding their appointment. Where necessary, this included any specific information regarding preparation by the patient, tests which may be necessary, and any specific information regarding what to expect if a treatment or test was required.

Access for all patients

- West Berkshire Hospital is a purpose-built building, and as such, had additional access arrangements for bariatric patients. In one waiting area, there were bariatric chairs available. This clinic booked a maximum of four bariatric patients per clinic. Many of the clinic areas at the Royal Berkshire Hospital had small areas within the main clinic for examination and consultation. The eye clinic reported issues with accessing the vision testing equipment for some people. This may mean some services may not be accessible to all patients.
- We asked reception and clinic staff what support and assistance would be provided to patients with a learning disability or living with dementia. They told us there were opportunities for the receptionists to fast-track patients through the usual waiting times if they found waiting distressing. Staff in one clinic told us that there were volunteers from Age-UK, who would support patients living with dementia who visited their department. This showed an understanding of the need for vulnerable people to receive extra support to access the service.
- Staff were aware of the specialist learning disability nurse, based at the Royal Berkshire Hospital, and said they would use her for advice and information should they need specific assistance with a patient. We saw that staff spoke with carers, if it was appropriate to do so, and they were able to accompany a patient into an appointment should they so wish. At the West Berkshire Hospital there was a patient with learning disabilities who had not received additional information; they did not know the learning disability nurse and they had no "all about me" document, which we were told all patients with a learning disability had in order for staff to understand their specific needs. This meant that the mechanisms put in place for supporting vulnerable people with their appointment were not always used in practice. There were no easy read leaflets seen, which would support people with a learning disability to understand how the clinic worked and what to expect from their consultation.

Requires improvement

Outpatients

- In the eye clinics there was signage in the font and colours recommended for the visually impaired. Staff also wore badges in this format.
- Staff told us that they had ready access to a translation service should they need it. This meant that patients, for whom English was not their first language, could engage fully in their consultation.
- Written information was not seen in any language other than English. The population of Reading has a non-white minority of 25%. When asked, staff were unaware if they could get leaflets or information in anything other than English. One clinic had introduced letters in other languages as a result of a staff member making this suggestion to their line manager. However, in other clinics, staff told us there was no mechanism for sending out letters in any language other than English. This demonstrated a lack of a consistent approach to ensuring that all patients can access the information they require.
- Signage around the hospital was poor and we saw patients and visitors on the corridors who could not find their way. This signage was not in any format other than written English. We did not see any signs in other languages, or formats such as pictures. This means not all signage would be accessible to all visitors to the outpatient departments.
- Staff were able to tell us how they could get the help of the specialist learning disability nurse if required to assist with the care and treatment of any patients. Staff spoke highly of this nurse, telling us they were a great asset to the hospital, and provided real support for patients and staff.
- Staff told us that any patient who was finding waiting difficult, due to any mental health issue, would be fast-tracked through the system to reduce the risk of raising their anxiety. Staff would also locate a separate quiet waiting area should this be required.

Communication with patients and GPs

- We found when we spoke with the medical secretaries that there was a large variation in the timescales for sending letters to the GP following an appointment. We were told by one secretary at the Royal Berkshire Hospital that the timescale was currently five to six weeks, whilst others reported they were within the week. The reason given for delays was a lack of administration staff, with posts being left vacant and no cover for sickness or holidays. This delay in a GP receiving a letter, following consultation, could, in turn, lead to a delay in a patient receiving necessary treatment, medication or follow-up. This could result in an unnecessary deterioration of their condition.
- Patients we spoke with said that if they had any queries regarding appointments they would contact the medical secretaries. The secretaries we spoke with reported that answering these calls added to their workload and was a source of interruption to them typing up dictated letters.

Environment

- Car parking at the Royal Berkshire Hospital was on a multi-storey car park, and patients said there was “very little” space to park. We were told by most people that this was one of the worst aspects of coming for an appointment. At West Berkshire Hospital there was ample car parking, and patients who attended both sites said they much preferred to go to West Berkshire due to the parking arrangements.
- Most clinics had children’s play areas, however, they were not available in all waiting areas.
- In both hospitals there was a coffee shop run by volunteers in the main reception area, with a wide range of snacks, and hot and cold drinks. We saw that these did not stay open for the duration of a clinic, and at approximately 3pm, during the eye clinic at the Royal Berkshire Hospital, when it was very busy, the shop closed. There were cold drinking water machines in some waiting areas. We found one of these had not been maintained as per the guidance on the machine, and another was out of order. This meant that in some areas patients could be waiting without access to food and drink.
- Seats were comfortable in the waiting areas, and some had a variety of seating, such as varied height, and spaces for wheelchairs.
- We were told by patients that wheelchairs to transport patients from the entrance to the clinics were not widely available. At 2pm, which was at the start of outpatients clinics, there were no wheelchairs at the main entrance. A volunteer welcome person told us that the trust had recently ordered 40 new wheelchairs to help with this issue.
- The trust also provided ‘buggies’ to transport patients from the main entrance to outpatients.

Requires improvement

Outpatients

- At both hospitals, there were patient information points, run by volunteers. These provided patients with directions to wards and departments, information about obtaining food and drinks, and any other information people required.
- In most areas, at the Royal Berkshire and at West Berkshire, there were a wide range of magazines available, as well as large television screens.
- Clinical staff, in several areas at the Royal Berkshire Hospital, such as the eye clinic and cardiac outpatients, told us that there was a lack of space, and the layout of the department led to reduced productivity. For example, the vision testing rooms in the eye clinic did not all provide a suitable environment for the equipment required in that space. One consultant told us there was not enough office space, in their clinic area, for dictating notes and making telephone calls. This could contribute negatively to the efficient running of the outpatient departments.
- Some areas of the hospital, where clinics were situated, were old buildings and, as such, staff told us that they experienced some issues. An example of this was an area which flooded in the diabetes and endocrine clinic, whilst in the ENT clinic there was difficulty obtaining hot water, due to the size of the water pipes. These issues had been reported to estates management; however, staff seemed resigned that they could not be resolved.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. We were told that initial complaints would be dealt with by the outpatient matron; but if they were not able to deal with their concern satisfactorily, they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. One staff member told us how they had managed a complaint immediately, by requesting the outpatient clinic lead nurse see the patient immediately and resolve the issue. This had been carried out, in confidence, to the satisfaction of the patient. There were leaflets and posters containing the complaints procedure available for patients in both hospitals. However, they were in written English, and were not seen in any other language or format, such as easy-read.
- Staff told us the learnings from any complaints received were shared. This was done during the weekly meetings held, between staff of all grades, within each department.

Are outpatients services well-led?

Requires improvement

The outpatient departments were well-led as individual services. The person in charge of each clinic provided support for staff, and had mechanisms in place for auditing various aspects of their service. There were systems in place to ensure that staff who worked in the clinics received the information they required, to learn from incidents and complaints, and there was a commitment to improve the experience of patients using the service.

We found that the clinics functioned in isolation of each other, and did not have an overarching vision or plan of how the outpatients services, within the trust, would continue to work towards improvement. There was a lack of structure for clinics to share their good practice with each other. Senior staff in the clinics were aware of the outpatient project, the draft report for which was dated July 2013; however, they did not know how the findings of this were to be translated into practice changes.

Leadership of service

- The main outpatient departments one and two, most specialist outpatient departments, and those at West Berkshire Hospital, are in the planned care directorate within the structure of the hospital management.
- The heads of departments we talked to all had many years' experience, and had obtained the qualifications necessary for their job. We were told by two people who were in senior positions that they had been supported by the trust, to develop their careers, and had worked through into the management position. Some continued to be supported to develop themselves through study, including attending relevant conferences to bring learnings back to their department.
- The heads of department we spoke with told us they felt involved with the management of the trust in that they were consulted and their views listened to. In turn, staff working in each department told us that they could talk to their line manager and could contribute to the running of the department. The staff below heads of

department level said they did not see the hospital executive team, and that they were unaware of them visiting their department. This meant that there was no visibility of the higher management of the hospital in the outpatients departments.

Culture within the service

- Staff we spoke with were very focused on providing a good experience for patients who visited their department. There were examples of where staff excelled in being patient-focused, such as staff in the orthotics department completing charity events, to raise funds for equipment and redecoration of the department, to provide a better service for their patients.
- We were told by staff that they were encouraged, by their immediate line managers, to report any concerns they had about the service, department or colleagues. They told us they could discuss any issues at their one-to-one meetings with their manager. Those staff we spoke with told us they all had regular one-to-one meetings, which meant they felt supported in their work.
- Staff we spoke with, at both hospitals, told us they enjoyed working within their department. Comments included "I wouldn't work anywhere else", from one staff member who had worked there over five years. Another member of staff at West Berkshire Hospital told us "it's a great place to work".
- We were told that there had been issues, with some staff feeling specific senior members of staff were addressing them rudely and not treating them with respect. This was described as "bullying" by one staff member, who also said that there was not an open and transparent management of issues raised by staff members, and they felt this deterred staff from reporting bullying.
- Within the outpatient departments that we visited, staff said they worked well as a team. They spoke about supporting each other and helping out if one area was short of staff. In the Royal Berkshire Hospital staff told us that in each clinic, they worked in isolation from any other outpatient department. The matrons of the departments, at both hospitals, met monthly to discuss any issues which may affect the outpatient departments as a group, and to share best practice. They told us they had good support from the director of nursing and could discuss any issues raised at these meetings with them.

Vision and strategy for this service

- The trust vision and values were not evident around the hospital. Some staff understood what this was, and how it affected their performance, as it was discussed as part of their one-to-one. Others were not aware of it. This showed that the understanding of the vision the trust has, is not communicated well to the wider organisation.
- One staff member who had been in post for six months told us that there was a trust presence during the induction training, and they outlined the vision and values, stressing the need to deliver good quality care. Other staff, who had been in post longer, told us there was little contact with the executives, and one staff member told us there "doesn't seem much consultation with the staff".
- There had been an outpatient's project commissioned by the trust, with a draft report having been produced in July 2013. There was a lack of understanding, from both senior staff and junior staff, at both hospitals, as to the outcome of this project, and any resulting planned changes to the department in which they worked. This meant that there was a lack of involvement of staff, by the trust, in the development of outpatient services.

Governance, risk assessments and quality measurement

- Monthly or bi-monthly clinical governance meetings were held, at department level, at both hospitals, and all staff were encouraged to attend, including junior members of staff. Staff of all levels told us they attended these meetings, if they were available, and they received information regarding complaints, incidents, risks and the performance of the department. One staff member at the Royal Berkshire Hospital told us how, as a result of issues discussed at these meetings, they had changed the way patients moved around in the department for procedures, which had resulted in less waiting time for patients. They told us all staff who attended the meetings could contribute their ideas, and staff from various posts we spoke with, at both hospitals, said the meetings were useful and inclusive.
- The head of outpatients at West Berkshire Hospital, and their equivalent at the Royal Berkshire Hospital, met monthly to share learnings and good practice. There

was no mechanism for these learnings to be discussed with the trust managers, and therefore the ability to change practice was the responsibility of the individual managers.

- Complaints, incidents, audits and quality improvement projects were discussed at the clinical governance meetings. One staff member told us they received results of audits and it was discussed how these impacted on the service and practice.
- Staff we spoke with in the individual outpatient departments, at both hospitals, could identify the challenges they saw to their own service. They told us these were their own identified challenges, and whilst some could identify that they were the same as the directorate, others felt they were isolated from the bigger picture. This included issues such as the decoration of their department and staffing requirements
- At West Berkshire Hospital a mechanism for administration staff to quality check letters had been introduced. This has reduced the errors being made in the letters sent from the department.

Innovation, learning and improvement

- The orthopaedic department matron had visited another trust, with two colleagues, to understand how “virtual fracture clinics” worked. They told us that there were plans to develop these clinics at the Royal Berkshire Hospital within the next few months. This would mean that patients who presented at A&E with a fracture may not need to present at clinic the following day. Rather, a multidisciplinary team would meet each morning, discuss the X-rays and decide the course of action. The lead nurse would then contact the patient, by telephone, and advise them on the decision. If they needed to attend a specialist clinic, for example, the hand clinic, an appointment could be made for them directly. It was thought this would reduce the throughput of patients to the orthopaedic clinic, and at the clinic they visited it had reduced the number of patients returning the following day by 80%.
- We were told by a senior member of staff at the Royal Berkshire Hospital that a graduate trainee was working on the development of self check-in booths for patients, which would reduce the reception staff numbers and speed up the check-in process.
- The manager of the orthotics department told us that they had recently commenced a project where they took the service into schools for children with disabilities. This included a physiotherapist, who had a specialist interest in orthotics. The project was in its infancy; however, it had been well received and feedback was being sought in order to assess the effectiveness.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of carrying out an assessment of the needs of the services user and the planning and delivery of care and, where appropriate, treatment to meet the needs and ensure the safety and welfare of the service users. Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Regulated activity	Regulation
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of carrying out an assessment of the needs of the services user and the planning and delivery of care and, where appropriate, treatment to meet the needs and ensure the safety and welfare of the service users. Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: The registered person had not ensured that equipment was properly maintained and available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs. Regulation 16 (1) (a) (2) Safety, availability and suitability of equipment

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: The registered person had not ensured that equipment was properly maintained and available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs. Regulation 16 (1) (a) (2) Safety, availability and suitability of equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The registered person had not, so far as reasonably practicable, made suitable arrangements to ensure the privacy and dignity of service users. Regulation 17 (1) (a) Respecting and involving people who use services

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: The registered provider must ensure service users are protected against the risks associated with unsafe or unsuitable premises by means of- suitable design and layout and adequate maintenance of the premises in connection with the regulated activity. Regulation 15 (1) (a) (ii) (c) (i) Safety and suitability of premises

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: The registered provider must ensure service users are protected against the risks associated with unsafe or unsuitable premises by means of- suitable design and layout and adequate maintenance of the premises in connection with the regulated activity. Regulation 15 (1) (a) (ii) (c) (i) Safety and suitability of premises

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18 Consent to care and treatment

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Compliance actions

How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18 Consent to care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18 Consent to care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider had not taken appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22 Staffing

Regulated activity	Regulation
Surgical procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider had not taken appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22 Staffing

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider had not taken appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: Service users were not protected against the risk of unsafe or inappropriate care and treatment arising from the lack of proper information about them by means of the maintenance of: an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided. The registered provider must ensure that records are kept securely and can be located promptly when required. Regulation 20 (1) (a) (2) (a) Records