Bracknell Forest Council

NOTICE OF MEETING

Health Overview and Scrutiny Panel
Thursday 3 July 2014, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health Overview and Scrutiny Panel

Councillors Mrs Angell, Baily, Kensall, Mrs McCracken, Mrs Phillips, Mrs Temperton, Thompson, Virgo and Ms Wilson

cc: Substitute Members of the Panel

Councillors Allen, Brossard, Ms Brown, Davison and Heydon

Observer:

Claire Turner, Healthwatch Bracknell Forest

Non-Voting Co-optee

Dr David Norman, Co-opted Representative

ALISON SANDERS
Director of Corporate Services

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Published: 24 June 2014

Health Overview and Scrutiny Panel
Thursday 3 July 2014, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

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***Note**: There will be a private meeting for members of the Panel at 6.45 pm in the Function Room*

AGENDA

Page No

1. **Election of Chairman**

2. **Appointment of Vice-Chairman**

3. **Apologies for Absence/Substitute Members**

   To receive apologies for absence and to note the attendance of any substitute members.

4. **Minutes and Matters Arising**

   To approve as a correct record the minutes of the meeting of the Health Overview and Scrutiny Panel held on 13 March 2014. 1 - 8

5. **Declarations of Interest and Party Whip**

   Members are requested to declare any Disclosable Pecuniary Interests and/or Affected Interests and the nature of those interests, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

   Any Member with a Disclosable Pecuniary Interest or an Affected Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

6. **Urgent Items of Business**

   Any other items which, pursuant to Section 100B(4)(b) of the Local Government Act 1972, the Chairman decides are urgent.

7. **Public Participation**

To receive submissions from members of the public which have been submitted in advance in accordance with the Council's Public Participation Scheme for Overview and Scrutiny.

8. **Frimley Park Hospital NHS Foundation Trust**

To meet Mr Andrew Morris, Chief Executive of Frimley Park Hospital NHS Trust, with particular reference to the Trust's services to residents of Bracknell Forest, and progress on the Trust's prospective acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust. 9 - 68

9. **The Patient's Experience**

To consider: 69 - 124

a) The results of the Care Quality Commission's 2013 survey of adult inpatients for Frimley Park, Royal Berkshire and Heatherwood & Wexham Park Hospitals NHS Foundation Trusts.

b) The current information from the NHS Choices website, for the NHS Foundation Trusts providing most NHS services to Bracknell Forest residents.

c) The perspective of the Bracknell and Ascot Clinical Commissioning Group on the quality of patient care at Frimley Park, Royal Berkshire and Heatherwood & Wexham Park Hospitals NHS Foundation Trusts.

10. **Protocol between the Health and Wellbeing Board, Healthwatch Bracknell Forest and the Health Overview & Scrutiny Panel**

To adopt the Protocol between the Health & Wellbeing Board, Healthwatch Bracknell Forest and the Health Overview & Scrutiny Panel, as recommended by the Health and Wellbeing Board. 125 - 134

11. **Departmental Performance**

To consider the parts of the Quarter 4 2013/14 (January to March) quarterly service report of the Adult Social Care, Health and Housing department relating to health.

Please bring the previously circulated Quarterly Service Report to the meeting. Copies are available on request and attached to this agenda if viewed online.

12. **Overview and Scrutiny Bi-Annual Progress Report**

To note the Bi-Annual Progress Report of the Assistant Chief Executive. 135 - 148

13. **Executive Key and Non-Key Decisions**

To consider scheduled Executive Key and Non-Key Decisions relating to Health. 149 - 152

Date of Next Meeting

The next meeting of the Health Overview and Scrutiny Panel has been arranged for 2 October 2014

HEALTH OVERVIEW AND SCRUTINY PANEL
13 MARCH 2014
7.30 - 10.00 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Mrs McCracken (Vice-Chairman), Mrs Angell, Baily, Finch, Kensall, Mrs Temperton, Thompson and Ms Wilson

Co-opted Member:
Dr David Norman

Executive Member:
Councillor Birch

Observer:
Mark Sanders, Healthwatch

Also Present:
Councillor Leake
Richard Beaumont, Head of Overview & Scrutiny
Glyn Jones, Director of Adult Social Care, Health & Housing
Mr Flowerdew, Royal Berkshire NHS Foundation Trust
Mr Robson, Royal Berkshire NHS Foundation Trust
Ms Morton, Royal Berkshire NHS Foundation Trust
Ms Hutchins, Royal Berkshire NHS Foundation Trust

49. **Minutes and Matters Arising**

The minutes of the Panel held on 4 February 2014 were approved and signed by the Chairman.

Matters Arising

Minute 47: Heatherwood and Wexham Park Hospitals (HWPH)
The Head of Overview and Scrutiny confirmed that a letter had been sent on behalf of the Panel to Monitor, the Care Quality Commission, the HWPH Trust and NHS England to express the Panel's concerns and lack of full confidence in the HWPH Trust. A response was awaited.

50. **Declarations of Interest and Party Whip**

There were no declarations of interest.

51. **Urgent Items of Business**

There were no items of urgent business.

52. **Public Participation**

In accordance with the Council's Public Participation Scheme for Overview and Scrutiny the following question was submitted by Mr Pickersgill, a resident of Bracknell Forest:

The Health and Social Care Act was delayed to add protection against Clinical Commissioning Groups (CCGs) commissioning care conflicting with their own financial interests. As many local GPs (including those on the CCG) have a financial interest in "Specialist Services" which offers specialist musculo-skeletal services and this will be a service at the Urgent Care Centre in Bracknell, how can we be assured that there will be adequate safeguards against such a conflict occurring?

A written response was provided by Mary Purnell, Head of Operations, Bracknell and Ascot Clinical Commissioning Group:

In line with any public body, Bracknell and Ascot CCG have procedures and safeguards against potential conflicts of interest. This can be a particular challenge for CCGs as CCGs are member led organisations, and our member practices are by definition providers of primary health services. For that reason, the measures to identify and manage conflicts of interest are rigorously applied. On a routine basis, the registers of interests are maintained and published on the website http://www.bracknellandascotccg.nhs.uk/ and declarations of interest are made at each meeting (internal and public).

Whenever a change to service was being implemented, and particularly where there was any procurement or other contractual issue, potential conflicts were managed by ensuring that no conflicted member of the CCG participated in the decision making process. Separate registers of interest were kept for those participating in any procurement, including staff and patient representatives who may be supporting the process. This was clearly stated in the Bracknell and Ascot CCG Standards of Business Conduct policy and in the Bracknell and Ascot CCG Constitution.

In the particular case of the musculo-skeletal assessment and treatment service currently being procured for the Healthspace, these processes were being diligently applied. The procurement was not yet complete, and no contract had yet been awarded, so no details can be made available regarding any organisation who may have bid to deliver the service. It was hoped that the procurement would be completed shortly and an announcement would be made at a forthcoming CCG Governing Body meeting. The service would not run from the Urgent Care Centre itself, but would be delivered from elsewhere in the Healthspace building.

The Director of Adult Social Care, Health & Housing reported that the CCG Governing Body met in public and also had a public participation scheme and so if the public wished to submit questions to them directly, they could do so. Details of these meetings were available on the CCG's website.

53. **Royal Berkshire NHS Foundation Trust**

Representatives from the Royal Berkshire Trust Mr Flowerdew, Mr Robson, Ms Morton and Ms Hutchins attended the meeting and made the following points:

- The Trust had undergone considerable scrutiny from Monitor and there were a number of reasons for this, including the Trust's financial situation, A&E waiting times and concerns around the Board's ability to deliver the work required of it.

- The Trust had initially been given a rating of one by the Care Quality Commission (CQC), this had now been reviewed and the Trust was pleased to report that CQC had given the Trust a rating of five. The initial rating had dismayed staff who had felt that their rating had always been a five. Mr Flowerdew considered that the methodology used by the CQC was somewhat arbitrary. The CQC would be inspecting the Trust again on 24-26 March 2014. Much preliminary work had been undertaken by the Trust to prepare for this and there would be a public engagement session held ahead of the inspection to gauge public views around services provided by the Trust. An external peer review would also be carried out.

- Monitor had been encouraged by the work undertaken by the Trust and there had been a public announcement made by Monitor to this effect.

- The waiting times currently experienced in A&E indicated that a review of the whole system was needed, the Trust recognised this and that their performance had been consistently below the Government target of 95% of patients to be seen in A&E within four hours. It was noted that the only Trust achieving this government target in Berkshire at present was the Frimley Park Trust. It was also noted that attendances at A&E were increasing year on year.

- It was reported that there had been a change in the type of patients being seen in A&E. There had been increases in patients needing resuscitation or with major issues and a decrease in the number of minor injury patients. Throughout the winter period there had been a larger than average attendance in the number of over 75's attending A&E. There was a particular issue with 'frequent fliers', where 69 people had accounted for some 1,000 attendances at A&E.

- It was reported that in terms of whole system actions, a Berkshire West System Recovery Plan had been agreed to improve performance and an operational teleconference was in place three times a week to monitor actions agreed within this, supported by Almanac. A whole system review had been undertaken by ECIST (Emergency Care Intensive Support Team) in March 2013. A steering group had been formed and an action plan developed to implement the recommendations from ECIST. A predictor model would be developed from data.

- The Director of Operations reported that the vision for the Royal Berkshire Bracknell Healthspace had been to bring care closer to home and create a modern, calm and patient centred facility. To reduce congestion at acute sites and provide innovative patient pathways. The Healthspace would also host other services such as the Urgent Care Centre, a base for GP out of hours service, Orthopaedic Physiotherapy, and MSK triage services.

- There had been a steady increase in patients choosing to attend the Bracknell Healthspace. Referrals remained linked to Clinical Commissioning Group contracts.

- In terms of renal and oncology services, Bracknell Forest residents could now choose to receive services locally where previously they would have had to travel to neighbouring areas such as Windsor or Farnborough.

The Chairman stated that the Urgent Care Centre was important for Bracknell Forest, he queried how financially sound the Centre would be over the next three years and also what was planned for the top floor of the building.
It was confirmed that the top floor would not be used; it would either be sold or rented. The Healthspace was already covering its own costs and operating at a surplus. If the facility was well used, it would remain financially sound. The debt of the building of £25m that would need to be covered over time.

The Panel queried to what extent patients could choose where they received oncology services.
It was reported that there was no contractual reason to prevent patients choosing where they would like to receive their care. If patients needed specialist care this could limit choices. There was currently a low proportion of Bracknell and Ascot patients at the Healthspace due to pre-existing contracts with commissioners. In individual cases, there might be technical reasons why a Bracknell resident could not receive treatment at the Healthspace.

The Panel asked if it would be possible for ambulances to be encouraged to be on stand by around the Urgent Care Centre, should patients need to be transferred to A&E.
It was reported that the likelihood of a transfer being necessary was small. If people arrived by car, they could continue their journey to A&E by car.

The Panel asked if there was any indication as to why the number of minor injury patients had now decreased at A&E.
It was reported that there were two likely reasons; the first that the information provided to the public was taking effect and people were using other facilities instead of A&E and secondly the incidence of minor injuries often involved sports injuries and these usually were reduced during the winter months.

The Panel queried the robustness of the Trust's IT systems as a recent experience had shown that a patient had been asked to give her personal details on four occasions to different staff during one stay at hospital.
It was reported that patient information was recorded electronically and that this shouldn't happen. The Trust had made progress in the way it shared information.

The Panel asked how the median wait time from arrival to treatment was calculated.
It was reported that this included the patient being assessed and history taken from the patient. A diagnosis being made and treatment implemented.

The Panel queried the nine hour and 22 minute wait times for A&E, that were not meeting the government target.
It was reported that these breaches were usually due to capacity issues, quite often waiting for a bed to become available.

The Panel asked if the Trust issued 'Hospital Leaving Letters'
It was confirmed that they were not issued, patients were formally discharged.

The Chairman queried the Trust's performance in terms of responding to Stroke patients within the target of 90%. The Trust was delivering at 69-70%.
It was reported that the target of 90% had been set with the CCG. Nationally the average performance was 56%. Delays usually happened in the night time after midnight when consultants were not available. The Trust was considering appointing an advanced nurse practitioner role; this would ensure regular support for Stroke patients. In addition, those patients that presented with non obvious symptoms may take more time to assess.

Councillor Kensall, the specialist member for patients complaints reported that he had met with the Trust in 2013 to discuss their complaints policy, he had been informed that the policy was been rewritten. Was the complaints policy now available?
It was reported that the policy had not yet been formally approved by the Trust's Board. The procedure for reporting complaints had been improved considerably. The new policy would be available from 1 April 2014.

The Executive Member for ASCH&H asked that if the Trust would be making numerous new appointments, how would the Trust be managing financially, given the difficult economic climate.
Representatives reported that the Trust was responding strongly to the 'Francis factor'. The new appointments would assure patient safety; this would include expanding the number of consultants at the Trust which had been recommended by Monitor.

The Executive Member for ASCH&H asked what activity the Trust would not be doing given that that funding was being allocated into these areas.
It was reported that all costs were being reviewed, the Trust's deficit would need to be addressed and consideration was being given to what activity the Trust could refrain from that would not impact patient safety.

Councillor Leake queried the concern from Monitor around the Trust's governance arrangements and if the Trust were satisfied that their governance arrangements were effective.
Representatives reported that Monitor had looked at two aspects which were that there had been three episodes where quality had been breached and secondly, the c.diff rates had spiked. These two aspects were seen as oversights on the part of the Board. Since the report by Monitor, the Trust was confident that measures had been put in place to resolve governance issues.

The Chairman thanked the Royal Berkshire Trust's representatives for a very informative discussion.

54. **SEAP (Support, Empower, Advocate & Promote) Complaints Advocacy Service**

Representatives from SEAP delivered a presentation explaining their role and activities, with reference to case studies and made the following points:

- The SEAP service was run across Berkshire and had been commissioned to provide the Independent Mental Health Advocacy and Community Mental Health Advocacy services for Berkshire by the Clinical Commissioning Groups. They were commissioned to provide the NHS Complaints Advocacy Service for Berkshire by the six local authorities.
- SEAP ensured that those with mental health issues had a voice and were properly informed and enabled to make informed choices.
- Anyone could refer to SEAP and SEAP were experiencing a steady rise in referrals.
- SEAP presented to the Panel a number of case studies to illustrate the kind of work they undertook.

The Healthwatch representative advised that whilst SEAP could take up individual complaints, the role of Healthwatch would be to consider issues, complaints and trends more generally. In addition, in the first instance, patients should always consider speaking to providers before contacting either SEAP or Healthwatch.

The Panel asked how SEAP would be informing the public about their service.
SEAP representatives reported that they were currently working on their marketing and promotion strategies. They would be running a number of drop in sessions across Berkshire, in various centres as well as attending the Healthwatch launch events and speaking on Radio Berkshire. SEAP worked closely with Bracknell Forest Voluntary Action to choose venues and community settings for their drop in sessions. Any ideas for venues would be welcomed from the Panel. SEAP also provided leaflets to all GP surgeries in Berkshire promoting their role. SEAP had its own complaints procedure if anyone wanted to complain about their advocacy service.

The Panel asked how SEAP would be liaising with Clinical Commissioning Groups (CCG's)?
It was reported that SEAP had already established regular contact with CCG's and leaflets about SEAP's role had been provided for all GP surgeries. CCGs had acted as a mouthpiece for SEAP at GP surgeries.

The Chairman thanked the SEAP representatives for a very informative presentation.

55. **The Patients' Experience**

The report asked the Panel to review the latest survey responses given by patients of Bracknell Forest GP practices and the current information from the NHS Choices website for the NHS Foundation Trusts providing most secondary NHS services to Bracknell Forest residents.

The Panel noted that much of the results had not changed significantly since the last survey six months ago. It was reassuring to see that confidence and trust in GP's remained good across surgeries. It was noted that there were issues around people being able to get appointments in a timely manner.

The Healthwatch representative reported that patient experience was an area that was of high priority to Healthwatch as whilst a high proportion of people were content with the health care they received, the service side of healthcare was more likely to raise issues. Healthwatch would be collecting soft data from the Urgent Care Centre to gauge the extent to which people were having difficulty getting appointments with their GP. Any good practice gleaned would be shared across the borough with practice managers. This work would also be shared with the Panel.

The Chairman felt that further work would be necessary around this in order for the Panel to explore the issues more robustly. It was agreed that this item be considered at the Panel's six weekly meeting to establish the focus of the work and to establish when the work could be brought back to the Panel.

56. **Applying the Lessons of the Francis Report for Health Overview and Scrutiny**

Councillor Mrs McCracken, Lead Member of the Working Group reported that this report had now been submitted to the Executive and had received some complimentary remarks from Executive Members. She thanked Working Group Members and the Head of Overview and Scrutiny for all their work. It was noted that the recommendations of this Working Group were now being put into practice.

57. **Departmental Performance**

In response to Members queries, the Director of Adult Social Care, Health & Housing (ASCH&H) reported that with reference to 6.9.2 of the report, pharmacies acted as a

frontline practitioner and were able to give people a range of advice this included advice around reducing harm caused by drugs and alcohol abuse.

The Director ASCH&H reported that the department's underspend was not as great as initially anticipated. Public Health activity was currently within budget.

The Chairman asked what the big issues were that most concerned the Director at the present time.

The Director reported that the big issue going forward would be the Better Care Fund. It would be a challenge to deliver the integration work required and the emphasis on diverting activity away from acute services. The entire pathway would need to be explored to deliver this effectively. The Executive Member for ASCH&H added that it was also imperative to ensure that the focus on the Better Care Fund was not undertaken to the detriment of other service areas in the department.

The Chairman stated that it would be useful to have the Better Care Fund on the agenda of a future Panel meeting.

Councillor Mrs Temperton reported that she and Councillor Thompson, as part of their specialist scrutiny role, had recently met the Public Health team and attended a workshop on sexual health.

58. **2013-14 NHS Quality Accounts**

The Chairman asked that all Members of the Panel read through each of the five Trust's Quality Accounts carefully. Consideration could then be given as to how Members wished to respond to each set of Quality Accounts. All responses would need to be made by the end of April 2014.

The Executive Member ASCH&H reported that the Quality Accounts for the Royal Berkshire Healthcare Trust reported very little about the Child & Adolescent Mental Health Services (CAMHS) specialist services, this was a concern as this was an area that wasn't performing very well. The Director ASCH&H reported that he was working with other Berkshire local authorities to address this issue. An action plan had been agreed and 15 recommendations had been made to NHS England around their specialist services around CAMHS. This had included that there wasn't currently any provision in the Berkshire area, young people with complex needs had to travel outside of the region to get the specialist support they needed. The recommendations also included the need to increase the capacity of out of hours services.

59. **Working Groups Update**

It was noted that Working Group activity had been postponed as currently Members would be following up work in their specialist areas.

60. **Executive Key and Non-Key Decisions**

The Panel noted Executive Key and Non-Key decisions relating to health.

61. **Date of Next Meeting**

3 July 2014.

CHAIRMAN

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HEALTH OVERVIEW AND SCRUTINY PANEL
3 JULY 2014

FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report provides background information for the meeting with the Chief Executive of Frimley Park Hospital NHS Foundation Trust.

2 RECOMMENDATIONS

2.1 That the Health Overview and Scrutiny Panel meets Mr Andrew Morris, Chief Executive of Frimley Park Hospital NHS Trust, with particular reference to the Trust's services to residents of Bracknell Forest, and progress on the Trust's prospective acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust.

3 REASONS FOR RECOMMENDATIONS

3.1 To inform the discussion with Mr Morris.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

5.1 The Panel determined at its meeting on 7 January that it would formally meet each major hospital Trust nearby at least once every two years. The last Panel meeting with representatives of Frimley Park Hospital on overall issues was on 2 February 2012. The minute of that meeting is attached.

5.2 To assist the Panel's deliberations, attached to this report are:

- Relevant summary information from the websites of Frimley Park Hospital, and Monitor
- The latest inspection report by the Care Quality Commission
- A briefing paper from Frimley Park Hospital on the proposed acquisition

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS / EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / CONSULTATION

6.1 Not applicable.

Contact for further information

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HEALTH OVERVIEW AND SCRUTINY PANEL
2 FEBRUARY 2012

Frimley Park Hospital NHS Foundation Trust

The Chairman welcomed the Chief Executive of Frimley Park NHS Foundation Trust, Mr Andrew Morris to the meeting and invited him to address the Panel on the provision of health services to Bracknell Forest residents. Mr Morris made the following points:

• He had been the Chief Executive at Frimley Park Hospital for 23 years and seen a lot of change in that time. Frimley Park served a collection of three towns that were very different and workload over the years had increased. In 23 years, the hospital had never overspent.

• Frimley Park Hospital had become a Foundation hospital in 2005 and had been rated highly through numerous inspections. The Care Quality Commission's spot checks had raised no concerns. The C. Difficile rate was the lowest in the south of England. Mortality rates were in the best decile nationally. Frimley Park's Maternity Services had been rated the second best in the Country and the National Patient Survey had placed the hospital in the top 20% of hospitals nationally. MONITOR is satisfied that the Trust's finances are sound. Frimley Park is a good hospital, the results spoke for themselves.

• Frimley Park served around 400 patients a month and staff at the hospital liked to work at the hospital. Happy staff equalled good care.

• The hospital strived to provide more consultant-led care and was currently trying to move towards 24/7 care. Maternity services had 8-9 hours of consultant cover daily, as well as a midwife led unit operating in close proximity.

• A new Trauma Unit was also to be developed which would include a helicopter pad on the roof of the hospital.

• Frimley Park had become the biggest provider for Bracknell Forest residents in recent times. The Chief Executive wanted to build contact with Bracknell Forest GPs, to respond to the interest shown by local residents. He was very committed to providing services to Bracknell Forest residents, particularly given current referral patterns. He was committed to the Healthspace and if GPs wanted a minor injuries unit, he would be happy to consider this.

• If patients had a bad experience at Frimley Park, he was keen to meet them personally or write to them.

• Frimley Park did currently experience problems with car parking, however they were working closely with Surrey Heath Borough Council to resolve this. It was hoped that another car park could be established at the back of the hospital.

• The hospital had an out of hours GP service that operated close to the hospital, patients could be sent there if they did not need A&E services. A local minor injuries unit in Bracknell would also take pressure away from A&E services.

• He stated that it was important that boundaries did not prevent Bracknell Forest residents from using Frimley Park.

• The hospital worked in close and successful collaboration with the Council's adult social care department, endeavouring to support and encourage people to remain in their own homes as much as possible.

The Chairman thanked the Chief Executive for his input and attendance and asked if it was possible for the Panel members to visit Frimley Park. The Chief Executive stated the Panel were welcome to visit the hospital.

From Frimley Park Hospital NHS Foundation Trust Website

Frimley Park Hospital is a leading NHS foundation trust hospital serving more than 400,000 people across north-east Hampshire, west Surrey and east Berkshire, although its catchment for some services such as emergency vascular and heart attacks is much wider.

In addition to the main hospital site at Frimley, it runs outpatient and diagnostic services from Aldershot, Farnham, Fleet and Bracknell, bringing a range of services closer to these communities.

Frimley Park was named as NHS Hospital Trust of the Year for the South of England in the Dr Foster Hospital Guide 2013.

Since becoming one of the first NHS hospital trusts in the country to achieve foundation status in 2005, Frimley Park has been able to use surpluses to invest in patient services. The summer of 2012 saw the culmination of one of the trust's biggest capital programmes with the completion of its multi-million pound new emergency department which is believed to include one of the biggest resus units in the country, with a day surgery unit above and helipad. It also opened its dedicated cardiology wing housing an accredited regional heart attack centre providing primary angioplasty, the gold standard emergency treatment for heart attacks, 24 hours a day, seven days a week.

These developments serve the strategic aim of underpinning the hospital's status as a hyper-actue centre. However, there have also been significant investments in elderly and end-of-life care.

The trust's maternity unit has an enviable reputation as one of the best in London and the South East. In 2012/13, 5,564 babies were born at Frimley Park. The unit was awarded the highest level 3 safety rating in the latest CNST assessment and was ranked joint top natinoally in the latest CQC survey of women's experiences.

Frimley Park is one of only a handful of trusts to achieve NHSLA level 3 safety ratings for both acute trust and maternity services.

Our friendly, caring and professional staff constantly strive to offer the best possible hospital experience for patients. In the last national staff survey, our staff were rated as the most motivated of any hospital in the NHS.

Frimley Park is also proud to host a Ministry of Defence Hospital Unit with military surgical, medical and nursing personnel fully integrated with the hospital's NHS staff providing care to patients in all specialties.

Frimley Park Hospital NHS Foundation Trust has strong links to the community through its 16,000-strong foundation trust members representing patients, other stakeholders and staff.

POTENTIAL ACQUISITION OF HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST

THE JOINT STATEMENT BELOW FROM THE BOARDS OF DIRECTORS OF BOTH FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST AND HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST WAS ISSUED IN FEBRUARY:

Following work in 2013 on an outline business case looking into the acquisition of Heatherwood and Wexham Park NHS Foundation Trust (HWPH) by Frimley Park Hospital

NHS Foundation Trust (FPH), the FPH board agreed in August to proceed to the next stage subject to further assurances from the relevant authorities.

The FPH board is now able to announce that it is in a position to begin work on a full business case which will examine the prospects of the acquisition in much greater detail. Finalising the full business case is likely to take several months and is due to be finished by the summer. Once completed it will form the basis of the case made to each trust's board and Council of Governors and to the Office of Fair Trading and Monitor, the foundation trust regulator, in seeking their agreement for the acquisition to go ahead.

The boards of both trusts remain in favour of the acquisition provided conditions are right. An acquisition would, for example, provide a larger catchment population to enable the enlarged trust to sustain existing specialist services.

The acquisition would also provide an option to develop the Heatherwood Hospital site as a centre for planned surgery to serve patients from both trusts' existing catchments, taking some pressure away from both the Frimley and Wexham Park sites.

However, no final decision has yet been made and the acquisition will only proceed if it is felt to be in the best interests of both trusts and the patients they serve.

End of statement

Note: The Office of Fair Trading is now known as the Competition and Markets Authority.

To date we have been sharing information about the potential acquisition publicly as and when we are able to. This includes liaising with our local health partners and outlining our position at public meetings, some of which have been reported in the local media.

Under the potential acquisition we would not be proposing any significant changes to local services or where they would be provided. Therefore we will not be holding a formal public consultation.

However we appreciate that there is a public interest and we have been including the latest information on the potential acquisition as part of our programme of health events across our local community.

These events are free and open to all. They are an opportunity for you to receive any news about the trust and to meet governors and senior managers, ask questions and raise concerns on all matters. Events are typically well attended with an average of more than 100 people at each one in the past year and everyone is welcome; you do not have to be a foundation trust member.

There are a number of health events being held across the area over the coming weeks. These are advertised on the Membership section of our website and circulated to all of our 15,000 foundation trust members.

In addition we will be continually reviewing how we keep you informed and address any queries and concerns as we get closer to a potential acquisition date.

Monitor Website

Monitor publishes 2 ratings for each NHS foundation trust.

- The continuity of services rating is Monitor's view of the risk that the trust will fail to carry on as a going concern. A rating of 1 indicates the most serious risk and 4 the least risk. A rating of 2* means the trust has a risk rating of 2 but its financial position is unlikely to get worse.
- The governance rating is Monitor's degree of concern about how the trust is run, any steps they are taking to investigate this and/or any action they are taking. They either indicate they have no evident concerns, that they have begun enforcement action, or that the foundation trust's rating is 'under review', which means they have identified a concern but not yet taken action.

Monitor's current ratings of Frimley Park Hospital Trust are:

Continuity of services – 4

Governance – Green

Monitor's additional comment is: 'No evident concerns'

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Care Quality Commission

Frimley Park Hospital NHS Foundation Trust

Frimley Park Hospital

Quality report

Portsmouth Road, Frimley
Surrey GU16 7UJ
Telephone: 01276 604 604
www.frimleypark.nhs.uk

Date of inspection visit:
7-8 and 14 November 2013
Date of publication: Janaury 2014

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.

Overall summary

Frimley Park Hospital NHS Foundation Trust is a single site trust with 725 beds serving more than 400,000 patients across north-east Hampshire, west Surrey and east Berkshire. However, its catchment for some services (such as emergency vascular and heart attacks) is much wider. In addition to the main hospital site at Frimley, the trust runs outpatient and diagnostic services in Aldershot, Farnham, Fleet and Bracknell, bringing a range of services closer to these communities.

Frimley Park Hospital also incorporates a Ministry of Defence Hospital Unit, with fully integrated military medics contributing to patient services.

Since achieving foundation trust status in April 2005, Frimley Park Hospital has been able to invest in a range of services, including a modern eye unit and a new emergency department that contains one of the biggest resuscitation units in the country. It has also opened its dedicated cardiology wing – this has an accredited regional heart attack centre that provides primary angioplasty 24 hours a day, seven days a week. There have also been significant investments in older people's care and end-of-life care.

Our inspection team spent two days visiting the hospital, and we conducted a further unannounced visit one week later. This included a night visit. We held a public listening event in Frimley Park and heard directly from about 100 people about their experiences of care. We spoke with more than 80 patients and over 100 staff during the inspection.

Our analysis of data from our 'Intelligent Monitoring' system before the visit indicated that the hospital was operating safely and effectively across all key services. The trust's mortality rates were as expected or better than expected across all key areas. When we inspected, we found that services were of a good standard at all times of day, including at night.

However, we had some concerns about the coordination and experience of care for people living with dementia. This included staff training and the documentation of people's needs. We looked closely at this when we visited at night, and found staff to be very caring and compassionate. However, we saw that they lacked training to underpin their skills. We also noted that staff were not consistently using the 'Blue Butterfly' system to identify people with dementia.

Summary of findings

Overall summary

We were particularly impressed by the leadership of the trust. This has been stable and consistent for a number of years and still remains dynamic and clear in its strategy for improvement. The executive team's passion for excellence was clear, and this created a workforce of dedicated staff caring for people at Frimley Hospital.

Staff were overwhelmingly happy working at the trust, and we met many people who had returned to work at Frimley because of the experience they had had there previously. This was particularly evident among the consultant doctors, many of whom had been junior doctors or trainees at the trust earlier in their career.

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?

Services were safe. Staff assessed patients' needs and provided care to meet those needs. There were procedures in place to keep people safe, for example from infections and from preventable falls. Staff maintained records to a good standard in most areas. The trust had clear reporting systems for incidents and was able to demonstrate where improvements had been made to improve safety.

Are services effective?

Services were effective and focused on the needs of patients. Outcomes for patients were mostly as expected or better than expected. The trust was meeting all key targets. It had a clear clinical audit system, and it used outcomes from this system to improve care.

Are services caring?

The vast majority of people said that their experience of care had been positive, and we saw many examples of this. The trust's patient survey scores matched the national averages. Patients said that they were satisfied with how staff had treated them, and that doctors, nurses and other staff were caring and professional. Staff respected patients' dignity and privacy.

Are services responsive to people's needs?

The trust responded well to patient feedback, and it had changed practice to improve the experience of people using the services. For example, it had taken patients' experiences into account when designing the A&E department. Through the trust's website, the Chief Executive invites people to contact him directly, and he responds in a timely manner.

The trust has a complaints process in place. Some people we spoke to felt that this sometimes fell short of their expectations.

Are services well-led?

The trust's leadership was exceptional and showed consistency in its approach. There was an obvious passion when leaders spoke about the hospital, and this was underpinned by a clear governance strategy and clear values.

Summary of findings

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

Accident and emergency

A&E provided safe and effective care. At the time of our inspection, the trust was meeting the national target of seeing and treating 95% of patients within four hours of arrival. However, it had failed to meet this standard in January, February and July of 2013. The department was well-led and staff were caring and responsive to people's needs.

Medical care (including older people's care)

The quality and delivery of care was consistently good across the medical services wards we inspected. We saw clear examples of effective leadership and compassionate care. The Medical Assessment Unit and the Stroke Units, in particular, delivered an exemplary standard of care despite being very busy.

Surgery

We found that staff assessed patients' needs and planned care to meet those needs. Staffing levels were acceptable on all wards and in theatres. Practices and procedures in theatres were safe. The trust routinely applied the World Health Organisation's Surgical Safety Checklist. The surgical wards had an 'early warning score' that detected any deterioration of patients' conditions and called for appropriate clinical support and assessment.

Most patients were satisfied with their care. However, some people said that not all staff had appropriate training to care for elderly people, especially people with dementia, and our observations confirmed this. Overall, we found that staff kept patients informed at all stages of their surgical treatment. However, there were a few instances when patients or their relatives had not been kept adequately informed. This resulted in patients feeling isolated. Patients told us that the wards were well-run and staff worked well with each other.

Intensive/critical care

There were sufficient numbers of suitably qualified nursing staff to provide safe and effective care. Staff assessed patients' needs, planned care and respected patients' privacy and dignity. We saw that staff were caring and compassionate, and that they included families in discussions, where appropriate. Family members told us that the care in critical care was excellent. There was multi-disciplinary team working within critical care, and clinicians informed us that they worked well as a team to provide a high level of critical care services.

We found that there could be delays in moving patients from critical care into appropriate wards, as beds were not always available. There could also be delays beyond the expected timescales for surgery to be performed, especially for procedures including hip replacements. We found that the critical care at this trust was well-led.

Maternity and family planning

The maternity department provided safe and effective care. Staff knew how to report incidents using the trust's incident reporting system. As a result, the department had learned from incidents and made changes to its practices.

Midwives had specialist areas of expertise to meet the needs of women using the service. Women told us that staff took good care of them. Staff said that there were clear lines of accountability in the maternity department and that they received the necessary training and supervision to fulfil their role.

Children's care

Children's services were safe, caring and well-led. The department was well staffed and there were effective systems for identifying and learning from incidents. Parents we spoke with felt involved in their children's care. The service was responsive to the needs of parents and children.

Summary of findings

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

End of life care

The trust provides a service that meets the needs of patients at the end of life, and their families. The palliative care team has a presence across the hospital and also provides outreach services and links with services in the community.

Outpatients

In outpatients, people received care that was effective and safe. The waiting areas were clean and well organised, with separate outpatient areas for children. Systems were in place to organise clinics effectively. However, we found that appointments were sometimes double-booked. This was because although the service had expanded, with additional doctors and support staff to deliver extended clinics, the demand for outpatient services had increased. Information was on display showing patients if appointments were delayed. Staff were responsive, and were able to guide and support patients at all times.

Summary of findings

What people who use the hospital say

Frimley Park NHS Trust scores in the Friends and Family Test showed that the average score for both inpatients and A&E were higher than the national figure.

In the Cancer Patient Experience Survey, the trust was in the top 20% of trusts in 25 questions and in the bottom 20% nationally on five of the 64 questions:

- Hospital staff gave information on getting financial help.
- Patient has seen information about cancer research in the hospital.
- Taking part in cancer research discussed with patient.
- All staff asked patient what name they preferred to be called by.
- Patient offered written assessment and care plan.

In the National Bereavement Survey 2011, the Surrey Primary Care Trust cluster was among the bottom 20% of all PCT clusters nationwide for eight questions. In the Adult inpatient Survey for 2012, the trust was in line with the national picture.

Data from the NHS Choices website shows the trust has an overall score of 4.5 stars out of 5 stars. Despite the good score and feedback from the majority of people, there are some negative comments.

Areas for improvement

Action the hospital MUST take to improve

None

Other areas where the trust could improve

- Ensure that the patient records generated in A&E are readily available and in a format which is accessible for other hospital departments.
- Improve the accessibility of specialist mental health care practitioners out of hours, especially for people using A&E.
- Continue to implement plans to improve care for people living with dementia.
- The mortuary leadership needs to take opportunities to improve hygiene safety standards.
- Do not attempt cardiopulmonary resuscitation forms with inpatient records need to be reviewed to ensure they are completed and up to date.

Good practice

Our inspection team highlighted the following areas of good practice:

- An emphasis on teamwork in A&E. The department was headed by a clinical director and a matron. Staff told us that the management team was open and approachable and that it provided good leadership. Staff said that this openness provided them with the confidence to challenge poor practice and raise concerns. Staff said that they had confidence in the management team and felt that any issues or concerns would be addressed in a timely fashion. Overall, staff told us they were proud to work for the hospital. The team appeared to be efficient and the concept of teamwork seemed to be evident within the department.
- End of life care.
- Junior doctor support and education.
- An open culture of learning from incidents and accidents in the areas of the trust visited.
- A highly visible and outstanding leadership team.
- A number of warm and sensitive interactions between staff and patients.

Frimley Park Hospital

Detailed Findings

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

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE, recent Clinical Vice President, Royal College of Physicians.

Team Leader: Sheona Browne, Care Quality Commission

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. Experts by experience have personal experience of using or caring for someone who uses this type of service.

The doctors on the team included senior consultant doctors, and the nursing staff included specialist clinical advisers, including nurses with board experience and experience of governance systems and theatres. The team also included a matron with experience of quality systems and a student nurse.

Why we carried out this inspection

We chose to inspect Frimley Park Hospital as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower.

Frimley Park Hospital NHS Foundation Trust was considered to be a low-risk provider. Frimley Park has been inspected five times by the CQC since it was registered in April 2010. At its last inspection (August 2012) it met the standards set out in legislation. In previous inspections, the trust was found to be not meeting standards relating to staffing, and respect and involvement of people who use services. However, it has been meeting standards since August 2012.

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

Detailed findings

Before the visit we analysed the information we already held about the trust and asked other organisations who work with the trust to give us their view. This enabled us to think about what questions we needed to ask and what observations we needed to undertake in order to answer the five questions.

We listened to people's views in a number of ways. We held a focus group with volunteer groups and people who find it difficult to get their voice heard. We also held a listening event in Frimley on 7 November 2013, at which over 100 people told us about their experiences. During the hospital inspection, we spoke to many patients, relatives and carers to find out what care was like.

We carried out an announced visit on 7 and 8 November and an unannounced night visit on 14 November. During these visits we held focus groups with different groups of staff and services users, and we carried out individual interviews with staff across all services and disciplines.

Additionally, we put comment card boxes around the hospital so that people could share their experience if they had not had the opportunity to personally do so.

Are services safe?

Summary of findings

Services were safe. Staff assessed patients' needs and provided care to meet those needs. There were procedures in place to keep people safe, for example from infections and from preventable falls. Staff maintained records to a good standard in most areas. The trust had clear reporting systems for incidents and was able to demonstrate where improvements had been made to improve safety.

Our findings

During 2012/13 the trust reported 53 serious incidents to the Strategic Executive System. Two of these incidents were never events (mistakes that are so serious that they should never occur). This shows that the trust is statistically within the expected control limits. Ward areas accounted for 44 of the serious incidents, and 16 of these were trips, slips or falls. A further five were in maternity and included two unexpected neonatal deaths and one intrapartum death.

Across the areas we inspected, there were systems to report incidents and staff understood how to use the systems. They felt confident about reporting incidents.

The trust could give examples of where it had made changes as a result of incidences. For example, in surgery some people told us that their care had not been successful and they had required readmission shortly after discharge. The trust had reported the risk of short readmission following discharge in its risk analysis, and it had already implemented changes with a view to improving safe discharge for patients. It had identified a lead nurse for implementing a safe discharge system across the hospital.

We did find some areas where the safety of people could have been improved:

- Records documenting decisions to not provide cardiopulmonary resuscitation (known as Do Not Attempt Cardiopulmonary Resuscitation, or DNACPR forms) were not fully completed in six of 17 forms we reviewed. The decision-making processes were not clearly documented and there was no evidence that decisions had been reviewed when a patient's circumstances changed. It was not always clear whether staff had assessed patients' capacity to understand the decision. This meant that a decision against resuscitation might be made without the knowledge of the patient or their next of kin.
- In the mortuary, there were opportunities to improve hygiene safety standards. The trust's Infection Control Committee had not informed or approved the cleaning and disinfection procedures, and we were concerned about the maintenance of the instrument disinfection equipment.

The wards at the hospital were well staffed. We looked at rotas for several areas over the months before inspection, and numbers were consistent. On the unannounced night inspection, the wards we visited were staffed well and staff were meeting patients' needs promptly.

The 2012 Department of Health Staff survey showed that 74% of staff said that they had worked extra hours. However, since then the trust had increased the nursing staff numbers by around 100.

Medicines were stored in accordance with their specific requirements. Where these needed to be stored in a fridge, we saw that staff had made fridge temperature checks. This ensured that medicines were kept in appropriate conditions for them to be effective.

Patients told us they were usually given all of their medications at the correct time. We saw staff giving medication only after they had made the correct checks. Staff said that pharmacy gave an excellent service to the wards.

Resuscitation trolleys in most areas had been checked in a timely fashion. However, in at least two wards there were gaps in the reporting.

There were assessments for managing risks to patient safety, such as venous thromboembolism (VTE), falls, malnutrition and the occurrence of pressure sores. This is supported by data showing that:

- Between August 2012 and August 2013 the trust had a lower pressure ulcer rate than the England average, with a spike in January 2013 being the only time where rates exceeded the average.

Are services safe?

- The trust's rates are lower than the England average for the majority of the period between August 2012 and August 2013. However, there was an increase in August 2013.

The trust uses red meal trays to identify patients who need help with eating. We saw staff helping patients with their food at mealtimes.

The hospital was clean and there was plenty of access to hand cleaning gel. The wards had safety notices on the notice board outlining their performance against key indicators of safe care, including infection control.

The trust's infection rates for Clostridium difficile and MRSA lie within a statistically acceptable range, taking into account the trust's size and the national level of infections.

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

Summary of findings

Services were effective and focused on the needs of patients. Outcomes for patients were mostly as expected or better than expected. The trust was meeting all key targets. It had a clear clinical audit system, and it used outcomes from this system to improve care.

Our findings

The mortality data for Frimley Hospital showed that there was no evidence of a risk of elevated mortality rates across the organisation.

However, the trust tends to have worse than expected mortality rates for people who have injuries and conditions due to external causes. On investigation, this would appear to be related to road traffic accidents. Frimley Hospital sits adjacent to a number of main roads and motorways. The accident department held regular trauma morbidity and mortality meetings to discuss the trauma activity within the department. Where it found that specific trauma cases could have been better managed to improve the patient journey or safety, it produced action plans and changed practice.

The trust had implemented recognised clinical guidance for end of life care and monitored practices. For example, it had drafted a revised *Policy for the Dying, Deceased and Recently Bereaved*. It had also issued new guidelines for the compassionate management of the dying patient following the removal of the Liverpool Care Pathway.

The trust results from the *National Care of the Dying Audit, 2011/2012* showed it performed among the top 25% of hospitals for seven of the eight key measures relating to the quality of care. This audit considered, for example, the availability of patient information, policies relating to patient care and outcomes from clinical care. The trust had developed an action plan to promote further improvement. One notable area still for completion when we visited was the provision of seven-day working for the hospital palliative care team.

The trust had introduced initiatives to improve the effectiveness of services for patients. Examples of these included the *This Is Me* booklet for improving services for people with dementia. However, we found that staff had not used these initiatives consistently.

The surgical wards had an 'early warning score' that detected deterioration of patients' conditions and called for urgent clinical support or assessment. In the theatres, the World Health Organization checklist for patient safety and checking was in use, and we observed staff correctly completing it.

Staff at the trust were well-trained and skilled to carry out their roles and responsibilities. We spoke with a group of junior doctors about their experiences of working in the trust. They described a high level of support from their consultants and registrars, and they said that this impacted on their personal confidence levels and medical practice. Many of the junior medical staff around the hospital told us about the work of a specific clinical tutor. They felt reassured by and cared for by this person, and they said that he was accessible and helpful.

However, we were concerned that there was a lack of consistent and ongoing training for staff caring for people with dementia. The trust recognised this, and it was in the process of reviewing of how it cared for patients with dementia across its services. This included a review of training and the appropriateness of ward environments.

We interviewed four consultants and a speech and language therapist about clinical audit and how it was implemented in the trust. They described clearly how clinical audit fitted into the trust's governance arrangements. The trust carried out 283 local audits across all specialities in 2012/13, involving over 200 staff. It was able to give specific examples of where it had changed practice as a result. For example, an audit of pain in children in A&E showed that there were times when children did not receive analgesic medication in a timely manner. After the audit, 100% of children in severe pain received medication within 30 minutes, and this met national standards. This had been achieved by adding a prompt to the A&E computer system to alert clinicians of the need for analgesic medication.

Are services caring?

Summary of findings

The vast majority of people told us that their experience of care had been positive, and we saw many examples of this. The trust's patient survey scores matched the national averages. Patients said that they were satisfied with how staff had treated them, and that doctors, nurses and other staff were caring and professional. Staff respected patients' dignity and privacy.

Our findings

The trust performs within the expected range in 10 of the CQC inpatient survey domains, and it scored in the top 20% of all trusts nationally in two questions.

In the August 2013 Friends and Family test, 95% of people said they would be either extremely likely or likely to recommend the inpatient wards. The A&E component scored seven points above the national average.

Frimley Park performs in the top 20% of all trusts nationally for 25 questions on the Cancer Patient Experience Survey, and in the bottom 20% for five. These five questions related to:

- Financial advice
- Not seeing information about cancer research in the trust
- Staff not discussing this information with them
- Not being asked what name they want to be called by
- Not being offered a written assessment or care plan.

Over 100 people came to the listening event to share their experiences of care. Many people came with very positive stories, but some did not. The main themes arising from comments about negative experiences were poor complaint handling, patients feeling that staff had not listened to them and care not meeting expectations, particularly for people living with dementia.

We saw many examples of kind and respectful care. We did see one interaction that was below expectation, but the trust dealt with this promptly when our inspector expressed concern.

In A&E, we spoke with 10 patients and reviewed over 60 letters and compliment slips dating from December 2012 to 30 October 2013. People spoke positively about the care they had received in the department. We were told that people felt safe because they were being cared for by staff who appeared to be competent and efficient. We saw that staff treated patients with dignity and respect and that they engaged positively and empathetically with patients and their relatives.

On the Stroke Unit, we heard one doctor explain treatment to an elderly lady. When they had finished their explanation, they took care to ensure that the patient had fully understood. We later heard the doctor talking to the relatives. They told us they were grateful for the compassion the doctor had shown to them, and to their family member.

We spoke with over 40 patients during the two-day inspection. Most of them told us they were happy with the service and the care they received. We heard one comment about a nurse speaking in a different language, and how this patient thought it was rude and inconsiderate. Many patients were keen to tell us of their experiences in Frimley, and they were overwhelmingly positive. Where people had raised issues with staff, they were usually to do with delays in the system, for example awaiting test results.

The majority of patients and relatives in surgical wards were satisfied or very pleased with their care. Some said that they got personal care quickly and that staff were always caring, kind and friendly. A few people told us this had not been the case and staff at times had been less than caring and abrupt. In one instance we witnessed a member of staff speaking to a patient abruptly, and we gave their name to the ward sister. The sister was already aware of the situation and had taken action. However, this person continued to not always treat patients with care and compassion. Patients and their relatives had given us other examples of a lack of care and compassion, especially for patients who had dementia or communication difficulties following a stroke.

Are services caring?

Patients told us they were treated with dignity and respect. For example, there were single-sex bays and single side rooms to ensure privacy and dignity for patients. Patients told us that staff had closed the curtains around their bed area for procedures and personal care, and we saw evidence of this. We saw one doctor asking a member of staff who spoke the same language as a patient to help them to translate to improve the patient's understanding. We saw staff helping people to move around and taking time to talk to people and reassure them. Throughout the inspection we observed staff at all levels smiling at patients, visitors and colleagues and assisting people with kindness and care.

Overall, women we spoke with were happy with the service in maternity. For example, they told us that nurses answered call buzzers promptly and when they needed pain relief, this was provided promptly. This meant women's needs were met quickly and in a caring manner.

We spoke with six parents whose children were being cared for. Five parents told us the care was excellent. One parent told us that staff were not as responsive to the needs of their child. For example, we found that the hospital had placed the child on material that could easily irritate the child's skin. When we showed this to the matron, she immediately took action and ensured the item was removed.

Staff said that end of life care was sensitive and caring. We were unable to talk with people receiving the service during our visit. We spoke with two junior doctors on different wards who had observed that staff provided end of life care in a dignified and considerate manner.

In 2012, the hospital surveyed patients' relatives for their views on the palliative care service, and obtained eight responses. The feedback was positive, with relatives reporting they were either satisfied or very satisfied with the palliative care team. During our visit we observed that a consultant met with a patient and their family, with the support of the specialist palliative care nurse, to discuss end of life care. This was carried out with discretion and in private.

There were issues with access to outpatient clinics. The volunteer driver commented that the hospital did not provide parking spaces near the entrance for volunteer drivers, or wheelchairs for them to take their clients to clinics. Although the cardiac clinic was highly regarded by the patients we spoke with, we saw that some people had difficulty finding it. This service was not situated near the main entrance, and we noted that one person needed help with finding it. The hospital had responded to this issue by assigning a dedicated porter to the service. However, we saw that other staff were also called on to fulfil this role.

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

Summary of findings

The trust responded well to patient feedback, and it had changed practice to improve the experience of people using the services. For example, it had taken patients' experiences into account when designing the A&E department. Through the trust's website, the Chief Executive invites people to contact him directly, and he responds in a timely manner.

The trust has a complaints process in place. Some people we spoke to felt that this sometimes fell short of their expectations.

Our findings

We examined trust data relating to the responsiveness of services and found that:

- In the accident department waiting times have improved recently and is now meeting the 95% target to be seen within four hours. The trust should strive to maintain this while not letting standards of care slip.
- The trust should consider its plan for managing the increasing pressure in A&E over the busy winter period so that it does not fall below the target again. If the trust can retain and improve its current level of service, it will continue to outperform the England average.
- The trust is performing as expected in relation to cancelled operations and delayed discharges. It is therefore not at risk in this area.

The trust had a process in place to monitor and review complaints and suggestions for improving services. It audited complaints, identified trends and took action where necessary. However, some people told us that the trust did not always respond in a timely manner and that it did not respond to their complaint to the expected standard. The trust received 431 written complaints in the 2012/13 time period, 23.4% of which were upheld. The 431 written complaints represent an increase of 16.8% from 2011/12.

On one of the medical units, the matron told us of a recent complaint she had received. She described how the trust had dealt with it by inviting the complainant to come in at a time convenient to them and asking how the situation could be solved to their satisfaction. We saw that the trust had taken action in response to this. This meant that the trust responded to the patients and relatives in question sensitively and in a timely manner.

The trust provided services to meet the needs of the local population. These included translation services, and a touch screen in the entrance which provided information about the hospital and services in a range of languages. The trust had employed staff who reflected the local population. This had been very helpful to some patients, but others told us this that it did not always make for easy communication. We spoke with staff about this, and they explained the measures they had taken during the recruitment process to ensure that staff were able to communicate effectively with patients and families.

Are services well-led?

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

Summary of findings

The trust's leadership was exceptional and showed consistency in its approach. There was an obvious passion when leaders spoke about the hospital, and this was underpinned by a clear governance strategy and clear values.

Our findings

The trust is well-led. The senior team had an outstanding passion for their work and service users.

The trust had a clear vision, and staff were clear about what that was. We interviewed many staff and everyone spoke highly of the leadership and their visibility. Staff at Frimley hospital said they worked 'for' Frimley not 'at' Frimley. The culture was open, transparent and caring. We witnessed many small interactions in the corridors that demonstrated how staff talked to and helped people in a kindly and thoughtful manner.

We met some staff who had gone the extra mile, for example a porter who was a dementia champion and had trained the other porters on how to treat people with dementia while pushing them around the hospital on trollies or wheelchairs.

The trust benefits hugely from a stable and long-serving leadership team, and the recent appointment of a new Director of Nursing has enhanced this. Nurses on the wards talked about how numbers of staff had increased, and they felt that this marked a new direction for them.

Staff sickness is 2.9% which is below the National average of 4.24%. And the staff survey found that Frimley Park staff reported better than expected against the national picture in 15 of the 28 questions asked. And when asked about the good communication between management and staff this was 10% higher than the national average.

The trust has recently launched its new vision and values, which have been determined by feedback from patients and staff.

It has succession plans for replacing the leadership team, as key personnel will be retiring in the next five years. For example, the Medical Director is retiring after 13 years in post, and he is mentoring the new incumbent to the post for up to a year.

Governance arrangements are clear and work well with underpinning strategies to ensure consistency and easy identification of risks. There is a joined-up process of looking at incidents, complaints and audits to ensure information is managed and discussed in order to improve care.

Leadership is conscious that the IT systems in the trust need to be replaced to ensure patient records are more smoothly managed. It is currently working with companies and universities to find the most appropriate solution and system.

With regard to dementia care, the trust understands the difficulties involved in ensuring good care, and it is looking at new ways of working across the hospital to improve the experience of patients and their families.

Throughout the areas we investigated, we saw examples of consistently good leadership:

- In A&E, staff told us that the management team was open, approachable and provided good leadership. Staff said that this openness gave them the confidence to challenge poor practice and raise concerns.
- In the Medical Unit, staff were very positive about the hospital leadership. The senior managers were known and respected. Junior staff nurses were able to tell us senior managers' names and roles. The Matron told us that the new Director of Nursing had improved staffing, was highly visible and was interested in staff opinions in ways to run the nursing service more effectively. Nursing staff on the medical units praised their Matron and the Head of Medical Nursing, describing them both as "hard working and available".

Accident and emergency

Information about the service

The accident and emergency (A&E) department had a total 38 beds with an additional five assessment cubicles. It consisted of 26 major and four minor cubicles, eight resuscitation area trolleys and a further 13 beds situated in the emergency department observation unit (EDOU). Last year the adult emergency department saw in excess of 75,000 patients. The paediatric emergency department was responsible for seeing and treating approximately 25,000 children during the previous year. The reception, majors, resuscitation and assessment areas had all been refurbished in 2012.

Summary of findings

A&E provided safe and effective care. At the time of our inspection, the trust was meeting the national target of seeing and treating 95% of patients within four hours of arrival. However, it had failed to meet this standard in January, February and July of 2013. The department was well-led and staff were caring and responsive to people's needs.

Are accident and emergency services safe?

There was sufficient equipment for resuscitating patients, and staff had been trained how to use it. Staff said they carried out equipment checks daily, and we saw this happening in practice. Six of the resuscitation bays were set up identically. This helped staff to become familiar with their working environment, so that appropriate equipment was to hand and staff could treat people in a timely manner. Two resuscitation bays had equipment for treating children of all ages. All staff received cardiopulmonary resuscitation (CPR) training. There were systems in place for ensuring that critically ill patients who required transfers were accompanied by qualified and competent staff. This minimised the risk to patients during transfers.

Between April 2012 and March 2013, the department had seen an increase in the number of people who had sustained a fall (24 to 36). The trend had been identified and reported in the department's clinical governance report dated 8 October 2013. The trust had attributed the increase in falls to the new A&E layout and an increase in the number of elderly patients treated in the department. We found that the majors cubicles were individual cubicles with doors and curtains; these cubicles had been installed to help improve patients' privacy and dignity. However, these new cubicles reduced the visibility of individual patients. The department had recognised that it needs to review this and had accepted that it needs to introduce new patient safety measures.

The trust said that it had discovered that a lack of standardised electronic patient record keeping had been problematic, as healthcare professionals could not always access the most up-to-date information for patients who may have been seen in other departments. A&E used its own electronic system, and staff told us that the system met their needs and was easy to use. However, staff from other departments told us that the fact that the system was only used in A&E meant that they had experienced difficulties in accessing patient information in a timely way. We identified a total of six different electronic patient information systems being used across the hospital. Staff told us they would still make entries in the paper patient notes but that comprehensive patient data would be stored electronically. The trust has embarked on an IT programme in an attempt to standardise the patient record system.

There were appropriate processes for safeguarding patients against abuse. The department also had a multi-disciplinary Safeguarding Children Group, which met weekly to discuss recent safeguarding referral forms and ensure that any necessary action was taken. The department demonstrated that it had learned from previous safeguarding incidents. For example, it had adapted the electronic patient recording system to remind all doctors to consider the safeguarding of vulnerable adults, especially those at risk of domestic violence. There were also systems in place for referring children and adolescents to the local Child and Adolescent Mental Health Service. Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.

Accident and emergency

There were 16 consultants employed to support the emergency department. Two consultants were specialists in paediatric medicine. Although A&E was not offering a 24/7 consultant-led service, there was direct consultant cover available from 8am to midnight, Monday to Sunday and additional 'on-call' consultant cover from midnight to 8am. The Clinical Director told us that the recruitment of middle-grade emergency care doctors had been difficult, due to a national shortage. In response to this shortage, the department had increased the number of consultants working on a daily basis to ensure that patients were safe and well cared for. During our two-day visit, there were four consultants working at any one time. We also observed a consultant-led handover at 4pm on our first day. We saw nursing and medical care staff of all grades challenging treatment decisions. Staff told us that the handover was a positive experience, as it encouraged multi-disciplinary treatment that was evidence based and allowed staff to learn from other colleagues. We saw that the handover process enabled staff to treat patients in the most appropriate way.

Are accident and emergency services effective?

The main adult department had a room dedicated to the treatment of people who presented with mental health problems. The room allowed people to be treated away from the busy majors area and was designed to offer people privacy and a degree of security. However, assessments to determine whether a patient required treatment under the Mental Health Act could only be carried out between the hours of 8am and 8pm each day. The mental health service was provided by a third party service, Surrey and Borders Partnership NHS Foundation Trust (SBPT). Staff working in the department said it was not uncommon for people to be admitted to the emergency department observation unit overnight if they required an assessment. We spoke to one patient who told us that they had used the service on a number of occasions and had been required to wait until the following day before they could be seen by a mental healthcare professional. The department had identified that a lack of access to out-of-hours mental healthcare services had a negative effect on people who use the service. As a result, it was liaising with SBPT and the local clinical commissioning group to improve the service.

Patients were assessed promptly by trained staff to ensure they received the most appropriate level of care. Patients who had been transported to the hospital by ambulance were assessed by an emergency medicine consultant within 15 minutes of arrival. Two paramedics that we spoke with told us that the A&E team was efficient and that they rarely experienced delays in handing their patients over to them.

The department had a system for managing patients who presented with symptoms associated with strokes and heart attacks and for people who had sustained injuries associated with trauma incidents, such as road traffic accidents. Patients with major injuries were seen by an appropriately qualified team and, if necessary, they could be transferred to a specialist unit once their condition had been stabilised. We also looked at the stroke care pathway and followed a patient journey to ensure that the care they received was consistent with national guidance. The trust monitored performance to ensure that people were transferred to the stroke unit or cardiac unit within specific timescales. This meant patients could be reassured that if they met the specific criteria for treatment, they would receive this treatment in a timely and efficient way.

The department held regular trauma morbidity and mortality meetings to discuss trauma activity within the department. Where the management of trauma cases could have been better managed to improve the patient journey and safety, the department produced action plans and changed practice.

The department had a major refurbishment in 2012. There is a 26-bedded majors area, which has been designed with individual cubicles to enhance the privacy and dignity of patients. There is a specialist bariatric majors cubicle, which has appropriate manual handling equipment to help staff manage obese patients. There is an eight-bedded resuscitation area, which was clean, tidy and well organised. The location of the resuscitation bay allowed rapid transfer of patients from the hospital helipad and ambulance bay; this design gave patients quick access to the specialist emergency care team. The paediatric emergency department was clean, bright and equipped with children's toys.

Accident and emergency

The four-bed minors bay had not been included in the original refurbishment, and although it was clean and tidy, it was not as bright as the rest of the department, and the general decoration was in need of attention.

Are accident and emergency services caring?

Patients received safe and effective care. We spoke with 10 patients and reviewed over 60 letters and compliment slips dating from December 2012 to 30 October 2013. People spoke positively about the care they had received in A&E. We were told that people felt safe because they were being cared for by staff who appeared to be competent and efficient.

Staff treated patients with dignity and respect. We saw staff engaging positively and empathetically with patients and their relatives. Comments from people included: "The care I receive here is exceptional", "The staff are very professional" and "I was informed of what was going on and I felt listened too. I was treated with great dignity and respect".

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

There was a process for monitoring and reviewing complaints and suggestions for improving the service. The trust audited complaints, identified trends and took action where necessary. Both the Matron and Clinical Director offered complainants face-to-face resolution meetings, which allowed people to talk through their complaint and gave the management team an opportunity to address any areas of concern.

One person told us that they were very hard of hearing and had felt isolated. They had experienced delays in treatment because they had not heard their name being called. We spoke with the Clinical Director about how people with special needs or disabilities were treated in the department. We were told that a new system had been developed to ensure that people with identified additional support needs would be escorted to the relevant area by a member of the reception team, who would then notify a member of the nursing team. We saw a person being escorted to the minor injury area on arrival at reception; the engagement between the patient and receptionist appeared to be empathetic.

We were told that people underwent a nutritional assessment on admission to the emergency department. If a patient was identified as being at risk of malnutrition, they were placed on a food chart and staff used a red tray to help identify those people who required support with eating and drinking. We did not see this process in practice during our visit. However, two staff we spoke with were able to describe the system.

The Department of Health's national target for A&E is that 95% of people should be seen and treated within four hours. The trust failed to meet this target in January, February and August of 2013. The Clinical Director told us that overall hospital capacity could sometimes present the department with difficulties in transferring patients from the emergency department to an appropriate in-patient setting. The trust was aware of the capacity problem and had undertaken a project to extend the number of in-patient beds that were available across the hospital to help ease the pressure.

Are accident and emergency services well-led?

The department was headed by a Clinical Director and Matron. Staff told us that the management team was open, approachable and provided good leadership. Staff said that this openness gave them the confidence to challenge poor practice and raise concerns. They said that they had confidence in the management team and that they felt that management would address any issues or concerns in a timely fashion. Overall, staff told us they were proud to work for the hospital. The team appeared to be efficient, and the concept of teamwork seemed to be evident in the department.

The hospital had introduced a set of three core values, which had been adopted by each of the staff members we spoke with. A&E had developed additional departmental values, which had been designed to enhance patient care, further improve staff morale and to develop a competent workforce through a local programme of training and education.

Accident and emergency

A robust clinical governance system was in place in the department. One consultant had been appointed as the governance lead, and regular reports were produced to demonstrate the effectiveness of the department. The report provided a balanced view of the department. The consultants we spoke with were clear about the challenges the department faced. They were each committed to enhancing the patient journey and were actively involved in some form of developmental working group within the department. For example, one consultant was leading on research into clinical leadership, and another was working with the emergency nurse practitioners to ensure that they were suitably supervised and skilled to carry out their roles.

Medical care (including older people's care)

Information about the service

The medical care services included acute and specialist medical units, general medical wards and care of the elderly. We inspected the Medical Assessment Unit (MAU), the Stroke Unit, two medical wards and a care of the elderly ward. We visited the discharge lounge, where some people waited for transport to take them home. We spoke with patients, relatives and friends, and staff, including registered nurses, care assistants, ward managers, senior managers, doctors and ward clerks. We observed care and treatment, and looked at care records. We heard comments at our listening event, and read information that service users had sent to the trust.

Summary of findings

The quality and delivery of care was consistently good across the medical services wards we inspected. We saw clear examples of effective leadership and compassionate care. The Medical Assessment Unit and the Stroke Units, in particular, delivered an exemplary standard of care despite being very busy.

Are medical care services safe?

Staff on the medical wards told us that staffing level levels were sufficient to allow them to provide safe care to patients. We looked at rotas for the previous two months, and these generally confirmed that staffing levels were consistent with the number of staff required for each clinical area.

We noted that medical units were constantly busy, but staff (including doctors and therapists) made time to provide compassionate care. We noted that ward clerks and domestic staff also made time, as they went about their daily tasks, to make conversation with patients.

Nursing staff told us that they had effective working relationships with medical staff and that they could access expertise easily and promptly. One nurse told us that this could occasionally be a challenge at weekends, but they said that things had recently improved. This meant that staff could make clinical decisions about treatment when they were needed, and this helped the service to meet patients' needs promptly. Patients told us they had sufficient numbers of nursing staff looking after them and that they did not have to wait long for help or care. One patient told us that they saw the medical staff daily, and that staff took time to answer any concerns or questions about treatment.

We noted that wards had emergency trolleys. We checked these and saw that stock was checked regularly, and that provisions were re-stocked as necessary against a checklist of requirements. Where there were bedside oxygen and suction points, these were clean and fit for purpose. Nursing and medical staff told us they had life support training relevant to their professional and unit requirements.

Medicines were stored in accordance with their specific requirements. Where these needed to be stored in a fridge, staff had carried out fridge temperature checks. This ensured that medicines were kept in appropriate conditions for them to be effective.

Patients told us they were usually given all of their medication at the correct time. Two people told us that if they required intravenous medications, these were sometimes given late because they took a long time to give. We saw staff giving patients their medication only after the correct checks had been made.

Staff said that the pharmacy provided an excellent service to the wards. However, two nurses and one doctor told us that discharges were sometimes delayed because of the pressure on the pharmacy to deliver medications within a specific timeframe.

Assessments were in place to manage risks to patient safety, such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were mainly consistent, although we noted one VTE assessment had been omitted on MAU. Staff told us that this assessment would be carried out before the patient was transferred to another medical unit. We later checked this patient's record and saw that this had been done. This meant that patients could be assured their safety was being assessed and managed.

Medical care (including older people's care)

Are medical care services effective?

We spoke with a group of junior doctors about their experiences of working in the trust. They described a high level of support from their consultants and registrars, and they said that this impacted positively on their personal confidence levels and medical practice. Many of the junior medical staff around the hospital told us of the work of a specific clinical tutor. They felt reassured by and cared for by this person, and said that he was accessible and helpful. Three people described how they were able to quickly order specialised scans for people who required them, so that they could begin treatment if necessary. This meant that patients could be assured that their treatment was appropriate, and that staff could treat patients in a timely manner.

We checked the ward equipment supplies and the methods of ordering stock and equipment. These were satisfactory. We heard that if staff requested a specialist item, it could take longer than usual to arrive. But staff were able to request it from a more specialist department. This meant that patients' treatment was not delayed due to a lack of ward stock.

We observed meal times on a medical unit. The trust had a protected mealtimes policy. This meant that all non-urgent clinical tasks stopped for a period of time so that patients could eat their meals without being rushed or taken off the ward for investigations. Patients who needed help to eat or drink had their meals on a red tray. This system alerted staff that they needed to give certain patients extra time and support. We saw examples of staff giving patients the help they needed. This meant that patients got sufficient nutrition without being hurried and with the support they required. We saw that this was an effective way to support people. The Stroke Unit also had an effective process for fortifying patients' diets, unless they opted out. This was evidence of research-led practice with good outcomes for this specific group of patients.

Are medical care services caring?

We saw a number of warm and sensitive interactions between staff and patients, particularly on ward F10. Although nursing staff were busy, the sister and a care assistant took considerable time to reassure and to explain things to patients before carrying out any care or treatment. This meant that patients fully understood the procedure to be undertaken.

On the Stroke Unit, we heard one doctor explain treatment to an elderly lady. When he had finished his explanation, he took care to ensure she had fully understood what he had told her. We later heard him talking to the relatives. They told us they were grateful for the compassion he had shown to them, and to their family member.

Most of the people we spoke to said that they were happy with the service and the care they received. One person commented that they had found it rude and inconsiderate when a nurse had spoken in another language. Many patients were keen to tell us about their experiences in Frimley, and they were overwhelmingly positive. Where peopled had raised issues with staff, they were usually to do with delays in the system for example, awaiting test results.

Relatives told us that they were often asked for their views and that this helped them understand what was happening to their family member.

We observed many examples of staff caring for and interacting with patients on medical wards. We heard staff speaking to people with respect and dignity, and addressing people by their preferred names. One nurse called her patients "sweetheart" and "darling", and when asked if she thought this was appropriate she told us that it was meant in a friendly manner. But she could understand why some older people may not think it was dignified. The following day, we heard her ask patients how they wanted to be addressed.

On every occasion we observed staff providing care, they drew the curtains around the patient's bed.

We heard many conversations between medical staff and patients. It was easy to overhear conversations because of the lack of private areas and the volume at which these conversations were taking place. Most conversations took place at the bedside. This meant that people in the vicinity could sometimes hear what was being said, and some of this information was of a sensitive and confidential nature. Patients and relatives could not be assured that private details were not inadvertently shared with those nearby.

Medical care (including older people's care)

Are medical care services responsive to people's needs?

At the listening event, a person told us about two complaints that had they had made to the trust. They praised the support of the Patient Advice Liaison and Support (PALS) service and the meeting they had had with the Director of Nursing. We heard that the Director of Nursing had taken the complaint seriously and had helped to resolve this issue.

On one of the medical units, the Matron told us about how the trust had dealt with a complaint she had received. It had invited the complainant to come in at a time convenient to them to discuss how the problem could best be resolved to their satisfaction. We saw that this meeting had led to the trust taking action. This meant that the patients and their relatives had their complaints dealt with sensitively and in a timely manner.

Although the trust does not have a ward specialising in care for patients with dementia, staff on the medical and care of the elderly units ensure that they are responsive to the needs of patients with this condition. We spoke with a clinical specialist nurse, and he described his role in the hospital and how this impacted directly on patient care and staff education. On one of the medical units, we heard that a care assistant was the recognised and nominated lead for dementia. The unit Matron told us how this worked at unit level, and showed us the interventions they used to help ensure that people living with dementia got the right care, support and services. Staff used the 'Butterfly' scheme to denote those who either had a definite diagnosis of dementia or displayed dementia-related behaviour. Staff then developed appropriate care plans with family and friends to ensure that patients' needs and usual behaviours were known. This meant that staff were better enabled to meet the needs of patients who had an acute medical condition and dementia.

Are medical care services well-led?

Staff were very positive about the hospital leadership. Junior staff nurses were able to tell us senior managers' names and functions. The medical unit Matron told us that the new Director of Nursing had improved staffing, was highly visible and was interested in staff opinions in ways to run the nursing service more effectively. Nursing staff on the medical units praised their Matron and Head of Medical Nursing, describing them both as "hard working and available".

Junior medical staff were heavily supportive of their consultants and registrars, and of the Clinical Director and Chief Executive. They explained why medical staff frequently returned to Frimley Park. One doctor said the level of support she had received in her day-to-day work was "outstanding", and other doctors there agreed. Another doctor told us that although the workload was sometimes very heavy, the senior staff "led by example" and were very approachable. One member of staff gave the example of a consultant helping a junior member of his medical staff to write up prescription charts.

Staff told us they had received regular supervision and appraisal and that they were released by their managers to attend the training they needed. One member of nursing staff told us this had "improved beyond belief" in the last year, since staffing had improved. Records we viewed confirmed staff attendance at training throughout the year. This meant that these staff had received training to help them meet the needs of patients.

Surgery

Information about the service

Frimley Park Hospital NHS Foundation Trust provides emergency surgical care and treatment to its local population. The hospital provides a range of surgery, including orthopaedics, general surgery, urology and gynaecology.

There are nine wards including a surgical short stay unit and a day surgery unit. We visited five of the wards, surgery areas, main theatres and day surgery theatres. These included the two general surgical wards, a surgical short stay ward and a day surgery ward for people with fractured hips. We spoke with patients, visitors and members of staff. We also held a focus group for consultants from all specialities, and this was attended by 22 surgeons.

Summary of findings

We found that staff assessed patients' needs and planned care to meet those needs. Staffing levels were acceptable on all wards and in theatres. Practices and procedures in theatres were safe. The trust routinely applied the World Health Organisation's Surgical Safety Checklist. The surgical wards had an 'early warning score' that detected any deterioration of patients' conditions and called for appropriate clinical support and assessment.

Most patients were satisfied with their care. However, some people said that not all staff had appropriate training to care for elderly people, especially people with dementia, and our observations confirmed this. Overall, we found that staff kept patients informed at all stages of their surgical treatment. However, there were a few instances when patients or their relatives had not been kept adequately informed. This resulted in patients feeling isolated. Patients told us that the wards were well-run and staff worked well with each other.

Are surgery services safe?

Staff assessed patients' needs and planned care to meet those needs. We reviewed a small sample of patients' records and found that they contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. This included pressure ulcer risk assessments, falls prevention measures and nutrition assessments. The records we saw had patient risk assessment records that were up to date and filled in appropriately. We saw a copy of a risk analysis that the trust had carried out in October 2013. This identified the risks of patients falling. As a result, ward sisters had implemented a falls improvement plan. On one ward they were using pressure mats to try to prevent falls. These alerted staff if people left their chairs or beds unnoticed and were at risk of falling. This meant that the department had identified a safety issue and taken action to improve patient safety. The data we had at the time of the inspection suggested that patient falls were below the national average for trusts of comparable size.

A very small number of patients or their relatives used our online form to tell us about occasions when they felt that care had not been successful, as they had required readmission shortly after discharge. Details of some readmissions had been included in the notifications of patient safety records that CQC sees regularly. The trust's risk analysis had highlighted the risk of short readmission following discharge, and the trust had already identified a lead nurse to improve the safety of the discharge process across the hospital. It had also asked clinical directors to provide assurance that consultants were reviewing patients prior to discharge.

Two patients in the day surgery unit told us that they had attended pre-assessment appointments where staff had carried out tests and had taken a full medical history. They said that staff had given them written information and had provided them with an opportunity to ask questions. We found evidence in the records that staff had assessed patients' needs prior to surgery and had carried out other checks on admission. This demonstrated a safe surgical process.

Surgery

Staff told us that the numbers of nurses on the wards had been increasing in the last few months. This was consistent with the trust's claim that it had recently conducted a recruitment campaign to provide additional staff in areas of greatest need. Staff said that where staff numbers had increased they were able to dedicate more time to patient care and provide a safer service. However, they said that although the number of consultants and nursing staff had increased, this had not always been supported by increases in the multi-disciplinary team, including physiotherapists and occupational therapists. This had meant there had been some delays in assessing discharging patients from surgical wards. The trust said that it had recognised this and that it was reviewing the need to increase multi-disciplinary support.

Staffing levels on the wards, in theatres and in the surgical assessment unit were acceptable. We found that wards were staffed by a mix of qualified nurses, students and healthcare assistants.

The trust told us how it had made changes to out-of-hours and weekend consultant cover, and it showed us a copy of Governance arrangements for weekend and out of hours consultant cover. The consultants confirmed that their hours had changed recently to reflect these new arrangements, providing safer care for patients and increased accessibility for trainee doctors who needed advice. Trainee doctors told us that they never had a problem accessing support or advice out-of-hours.

The wards we visited were clean, and hand sanitizers were available outside wards, bays and side rooms. Information on infection control was displayed at strategic points. Personal and protective equipment such as gloves and aprons were available in sufficient quantities. We saw staff using hand gels every time they visited a patient and as they entered or left the ward. We observed infection control practices in theatres and saw that staff were following these. Staff had also been trained in how to minimise infections.

Patients told us that the ward areas were regularly cleaned. One person told us that checks were made on the standards of the cleaners' work once they had finished cleaning. We asked staff when the day surgery unit had last been deep cleaned and were informed this had taken place in September 2013. Staff said this usually took place every six months but that curtains were changed frequently and regular cleaning took place routinely and as necessary.

There were processes in place for monitoring patient safety. We saw data on patients contracting MRSA and Clostridium difficile, and these were within nationally agreed rates. The trust told us it had taken action to improve the prevention of hospital acquired infections. Where incidences had occurred, the department had carried out investigations and shared the learning across the wards. Departments and wards applied the surgical venous thromboembolism pathway, designed to reduce the incidence of thromboembolisms such as deep vein thrombosis.

Practices and procedures in theatres were safe. The trust used the World Health Organization Surgical Safety Checklist, which was designed to reduce any potential complications from surgery. Our check of patient records revealed that the checklist was in operation and that staff were recording information appropriately. This showed care was safe and appropriate checks were in place.

Are surgery services effective?

The majority of patients we spoke with told us that their treatment had been effective at each stage, from admission as an emergency or referral by the GP to successful surgery and recovery. People told us that they had been impressed by the services of the cardiology and cancer specialities as well as other areas of the service. One person told us, "The service was effective at every stage, I had lots of information, the waiting times were reasonable or quick, and the staff were always helpful." However, a small number of other patients told us that their care had not been effective. People said they had to wait too long in the pain clinic at times, causing them more pain. Some patients said they had requested pain relief on some wards, but staff had not responded effectively in a timely manner.

The trust works in collaboration with three local authorities, due to its geographical position. The consultants we spoke with recognised that at times this could cause difficulties in providing effective, timely multi-disciplinary care and services. This was particularly applicable to discharge arrangements.

Surgery

We saw that the trust had introduced initiatives to improve the effectiveness of services for patients. Examples of these included the This is me booklet for improving services for people with dementia. However, we found that staff were using these initiatives inconsistently.

The surgical wards had an 'early warning score' that detected deterioration of patient's conditions and called for urgent clinical, support or assessment. Staff showed us the processes and the protocol that were in place. This system ensured that staff gave patients the right care at the right time. There were weekly multi-disciplinary discharge meetings. Ward rounds were also multi-disciplinary. Patients we spoke with told us that they were able to speak with the doctor and ask questions during these rounds. This confirmed that effective processes were in place to meet patients' needs and that the trust was aware of areas for further improvement.

Are surgery services caring?

The majority of patients and relatives we spoke with were satisfied or very pleased with their care. Some said that they got personal care quickly and that staff were always caring, kind and friendly. A few people told us this had not been the case and that staff had at times been abrupt or less than caring. We saw a member of staff speaking to a patient abruptly, and we gave their name to the ward sister. The sister was already aware of the situation and had taken action.

However, some patients and their relatives had given us other examples of a lack of care and compassion, especially for patients who had dementia or communication difficulties following a stroke. We were told that on one occasion a patient had asked for help to move up the bed and had been told to do this themselves, even though they were unable to do so. In one ward, we saw that an agency nurse and a healthcare assistant were failing to provide care and compassion to two people with dementia. In one case a patient asked for the toilet and when we asked the nurse to assist them we were told they were incontinent and should go in their pad. When we raised this with a nurse in charge, we were told that this was not accepted practice and that staff should have helped the patient use a commode.

The hospital used a red tray system to identify patients who needed assistance or supervision with their meals and drinks. This ensured patients received appropriate care at mealtimes. All wards had protected mealtimes when staff ensured people could eat without interruption from visitors or other staff. Staff helped patients to eat their food where necessary. They told us that generally this protected meal time was respected but that at times unavoidable interruptions did occur, for example if a patient needed to attend a test in a different area or clinical staff had only limited time to see a patient. Some relatives told us that staff were not always helping patients with dementia to eat their meals. One relative told us that all the patients in a ward had been moved and one person had been asleep, and they had therefore missed breakfast. They were not offered an alternative when they woke up.

Patients told us they were treated with dignity and respect. For example, there were single-sex bays and single side rooms to ensure privacy and dignity for patients. When personal care was provided, we saw staff pulling curtains around the bed. Patients confirmed that staff had closed the curtains around their bed area for procedures and personal care. We saw one doctor asking a member of staff who spoke the same language as a patient to translate and help a patient understand what was being discussed. We saw staff helping people move around and taking time to talk to people and reassure them. Throughout the inspection, we saw staff at all levels smiling at patients, visitors and colleagues and assisting people with kindness and care.

Surgery

Are surgery services responsive to people's needs?

Overall we found that staff kept patients and their relatives informed about their treatment. However, there were a few instances when this had not happened, and patients or their relatives had been left feeling isolated.

Services had been provided to meet the needs of the local population. These included translation services, and a touch screen in the entrance, which provided information about the hospital, and services in a range of languages. The trust had employed staff who reflected the local population. This had been very helpful for some patients, but others told us this did not always make for easy communication. We spoke with staff about this, and they explained that measures they had taken during the recruitment process to ensure that staff were able to effectively communicate with patients and families. Senior staff accepted that they could do more to ensure that new staff could fully understand and be understood and therefore meet the needs of all of the patients they cared for.

Staff were able to describe the complaints procedures. We saw that complaints leaflets were available throughout the hospital, but these were not always the most up-to-date version. When asked, some patients were not aware of how they could make an official complaint. The majority of patients who spoke to us and who had made a complaint had been satisfied by the response from the trust. However, some people informed us that they had not been satisfied with the response, as it had not dealt with their individual and had consisted of a letter with standard phrases. They did not feel this was adequate or respectful. One person told us that there had been a long delay in the hospital responding to their complaint. We found that the trust did implement its complaints procedures and that the timescales for responding to patients had generally been met. We found that complaints were regularly reviewed by senior staff and lessons learnt passed on to the relevant staff or departments. We found that the trust had offered meetings to patients or their relatives in an attempt to resolve complaints.

Are surgery services well-led?

Patients told us that the overall service was good and that the wards were well run. They told us that staff worked well with each other.

The consultants who expressed an opinion spoke highly of the leadership at this trust and the way the clinicians worked together and supported each other.

Staff told us they had opportunities to give their views about the service at ward, departmental and senior levels. They said that the senior managers demonstrated an open and approachable attitude.

We saw that there was a management structure in place for the surgical unit. Each ward was led by a ward manager or sister. The matron was there to provide overall leadership for the ward. The sisters and matrons we spoke with were fully aware of their roles and responsibilities. For example, they told us that the management team would not challenge their decision to provide additional staff to wards that needed them. One senior clinical member of staff told us, "Patient safety and patient care comes first at this hospital." We found that processes and systems in theatres and on surgical wards were well managed and safe.

Intensive/critical care

Information about the service

The trust provides a critical care service to support the needs of patients at Frimley Hospital. There is an intensive care unit and an outreach intensive care team.

Summary of findings

There were sufficient numbers of suitably qualified nursing staff to provide safe and effective care. Staff assessed patients' needs, planned care and respected patients' privacy and dignity. We saw that staff were caring and compassionate, and that they included families in discussions, where appropriate. Family members told us that the care in critical care was excellent. There was multi-disciplinary team working within critical care, and clinicians informed us that they worked well as a team to provide a high level of critical care services.

We found that there could be delays in moving patients from critical care into appropriate wards, as beds were not always available. There could also be delays beyond the expected timescales for surgery to be performed, especially for procedures including hip replacements. We found that the critical care at this trust was well-led.

Are intensive/critical services safe?

The department is fully compliant with NICE 50 (the clinical guidelines on how to identify and care for patients whose health worsens). Staff assessed patients' needs and planned care to meet those needs. For example, they filled in daily observation sheets. We saw staff caring for patients in a timely manner. This showed that patient care was delivered as planned to meet patients' needs.

The critical care areas were clean, and hand sanitizers were available near the beds and throughout the wards. Information on infection control was on display at strategic points. Personal and protective equipment such as gloves and aprons was available in sufficient quantities. We saw members of staff using the equipment and hand gels every time they visited a patient and when they entered or left an area. Staff told us they had completed regular infection control training, and this was confirmed by the records we reviewed.

There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas provided a balanced skill mix and allocation of staff. There was always a senior nurse identified as the lead for the unit, 24 hours per day. The trust had recently worked with clinicians to increase the available hours of consultants so that trainee doctors had suitable access to support and advice and consultants attended as required.

Critical care staff used an 'early warning score' that detected deterioration of patients' conditions and called for urgent clinical help. This system ensured patients were provided with the right care at the right time.

We found that records to demonstrate that vital life support equipment had been checked were in place. Equipment was well organised and stored appropriately.

The critical care and wider trust staff had identified learning from incidents and used these to improve the safety of services.

Are intensive/critical services effective?

The consultants told us that they worked well with their colleagues and that this ensured an effective service was provided to patients in critical care. We agreed with this assessment, because patients and relatives told us the service they or their family had received had been effective. This was further confirmed through the records we reviewed. We found that patients and their relatives had access to relevant information and that staff were available to answer their questions.

We found that staff had necessary training in critical care skills and that there were effective links between the intensive care unit and other critical care areas. This meant that staff had the training to provide an effective service.

Patients spoke highly of the physiotherapist services. One previous patient who had spent time in the intensive care unit said, "They were great and aided my recovery."

Intensive/critical care

We found that staff were maintaining appropriate records, which demonstrated that patients' needs were met. In general they completed patients' fluid and food charts accurately.

The dashboard measures which the trust carried out as part of the audit process demonstrated that the availability of beds in appropriate areas had been a problem. In practice, this had meant that on one occasion a patient had spent two days in recovery rather than being transferred to the ward. This had been due to the lack of a bed in an area where male patients could be cared for.

Are intensive/critical services caring?

Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs.

Family members referred to care in the Intensive Therapy Unit (ITU) as "excellent". Staff kept them regularly updated on the condition of their relatives. They told us that staff could not do enough for them. One patient said, "I had the utmost care, and I can't praise the doctors and nurses highly enough."

We saw that staff were very caring throughout the critical care areas. We heard staff responding kindly to patients and relatives and attending to patients' needs in a timely manner.

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

The hospital had an ITU outreach team which was led by a consultant nurse. The team provided a service from 8am to midnight, seven days a week. Out of these hours, the consultant from critical care and the hospital at night team were in place to deal with any emergencies. Its remit included bed management and dealing with people who develop early warning scores triggers (people whose condition is getting worse). It also responded by reviewing patients who staff were concerned about. Staff told us that the outreach team worked well and was responsive to the needs of patients on the wards. They shared with us examples of how patients were transferred to ITU following the early warning system and explained the response from the ITU outreach team. On one occasion, a transfer took place out of hours. This showed that the service was responsive to patients' needs.

The department had carried out a survey of the views of relatives. Responding to the feedback, it was going to put in place accommodation for relatives. The trust showed us the accommodation plans. The department had a plan to follow up patients who leave the Intensive Care Unit. Staff had already undertaken training to enable this. The follow-up of patients was linked to the rehabilitation pathway.

Are intensive/critical services well-led?

There were dedicated medical and nursing staff with overall responsibility for critical care. They were aware of their roles and responsibilities and were accountable to the Director of Operations and the Director of Nursing for professional matters. We were told that for the present capacity, the numbers of nurses to patient staffing ratios were acceptable. This meant that there were enough suitably qualified skilled nurses to provide patient care. We did find that the level of staff sickness was at 3.8%, which was higher than for other areas of the trust. The leadership team was aware of this and it had made changes to the management structure and provided additional staffing with the aim of improving these figures and providing a more effective service.

Maternity and family planning

Information about the service

Frimley Park Hospital NHS Foundation Trust provides community and inpatient services. The service cares for around 5,200 women and their families a year. Facilities include two labour wards. There is a dedicated operating theatre and a special care baby unit. During our inspection, we visited the antenatal clinic, the antenatal, labour and postnatal wards and the special care baby unit.

Summary of findings

The maternity department provided safe and effective care. Staff knew how to report incidents using the trust's incident reporting system. As a result, the department had learned from incidents and made changes to its practices.

Midwives had specialist areas of expertise to meet the needs of women using the service. Women told us that staff took good care of them. Staff said that there were clear lines of accountability within the maternity department and that they received the necessary training and supervision to fulfil their role.

Are maternity and family planning services safe?

Women told us that they were happy with the services the hospital provided. There was a system in place to identify, analyse and review risks, adverse events, incidents, errors and near misses. For example, after a recent 'never event' (mistakes are so serious that they should never happen) the department put solutions in place to reduce risks. It ensured the lessons from the never event were widely publicised internally through newsletters and sharing of information at meetings. Members of staff were aware of actions taken to prevent such an error happening again. This meant that the service managed risks effectively.

Staff told us they knew how to report incidents using the trust's incident reporting system and that they were kept informed about the incidents reported and any learning as a result of these incidents. Incidents were also discussed at team meetings. This demonstrated that there were systems in place to manage risks and improve the care provided to mothers and babies.

We spoke with the Head of Midwifery, who told us that arrangements were in place to ensure sufficient numbers of staff to provide safe care. Midwives told us that the staffing levels were appropriate across the trust. This meant that the department was a safe environment for women to give birth to their babies. The department had the standard ratio of one midwife to 33 patient hospital births. We reviewed the data for one year and found the ratio was maintained consistently on a monthly basis. The department had also introduced 12-hour shifts, and staff were happy with the working arrangements. There was also consultant/critical care cover (132 hours per week) throughout the week and including weekends. This meant the department provided safe care to women.

The department had pathways in place for women who needed consultant-led care. For example, we saw that the World Health Organization Surgical Safety Checklist for maternity was in use. This surgical safety checklist helps clinicians to improve the safety of patients. We inspected six maternity records and found that staff had completed the checklist appropriately. This ensured there were effective systems in place to ensure women received appropriate care.

The trust had a postnatal obstetric early warning system. This system compared the vital signs of a woman to expected levels, and staff took action when they fell below certain levels. Staff told us that they were aware of this system and that they knew what actions to take. This ensured there were effective systems in place to ensure women received appropriate care.

The environment was clean and tidy. Women told us that staff always complied with infection control procedures. They saw them washing their hands regularly after seeing a patient. There were posters throughout the department informing members of staff on the importance of infection prevention and control. For example, the unit had access to a 24-hour cleaning service. This meant members of staff were aware of their responsibility to minimise healthcare associated infections.

Maternity and family planning

Staff checked emergency trolleys on the labour ward on a daily basis. This ensured that equipment was available when needed.

The department had a number of clinical policies and procedures in place, including procedures for identifying and caring for women who develop gestational diabetes. This meant that women who developed diabetes during their pregnancy were provided with appropriate care to manage this condition.

There were also good links with safeguarding, mental health teams and the local council's domestic violence team. This meant that women who needed help were able to access the right services.

Are maternity and family planning services effective?

The maternity and special care baby unit (SCBU) was appropriately equipped and maintained. Staff told us that they were able to get the equipment they needed to ensure women received effective care. The SCBU was going to be moved to a separate part of the hospital to ensure that it had sufficient space. We spoke with midwives who welcomed this, and they told us that the trust had consulted them on the move.

We found that midwives had specialist areas of expertise to meet the needs of women using the service. For example, women could access support in infant feeding and diabetes. There were also midwives who had been trained to work with women who had experienced bereavement. On the day of our inspection, there was an incident where a mother had lost her baby. We found the service effective in helping family members as they experienced the loss. One midwife told us, "The standards of service in this place are very high."

Women were supported in their choice of how to have their baby. The options available included an obstetric-led delivery suite or in the community. At present, the trust does not have a midwifery-led birthing unit. After a woman left the unit, staff made telephone contact with her on day 1, day 5 and day 10 after which care is handed over to health visitor. We spoke with a woman at the postnatal clinic, and she told us that this was much appreciated and provided her with assurance when she needed to raise concerns. This meant that the services provided were effective.

We also visited the antenatal clinic. While the clinic was busy, we found that there was good level of patient care. One woman told us that the waiting times could be improved. However, she was given an appointment to see the consultant very quickly. We found that a consultant was always on duty, and if members of staff had any concerns, they could seek the necessary medical support. This ensured women received effective care.

Are maternity and family planning services caring?

The department undertook a survey of women who used the service. It shared the results with members of staff in the department on a regular basis. The department also received comments from mothers. Previously, the department held focus groups for women who had recently used the service. This had stopped, and there were plans to restart this initiative. This demonstrated that the department was committed to finding out how it could meet the needs of women.

Throughout our inspections, we saw members of staff providing a high standard of care and maintaining patients' privacy and dignity. One woman told us, "There is lots of choice here. I would have another baby here." However, another woman told us that she had to wait to use the showers because the department was busy. Overall, women were happy with the service. For example, they told us that nurses answered call buzzers promptly, and when they needed pain relief, this was provided promptly. This meant women's needs were met quickly and in a caring manner.

We spoke with women who felt that the overall patient experience was positive. During our inspection, we spoke with one expectant mother who told us that the department provided her with a porter and wheelchair, as she was asked to walk around the hospital to facilitate the birthing process. Women also told us that staff took good care of them. For example, they offered them a variety of choices for foods for lunch and dinner. This demonstrated respect and an ability to provide services in a caring manner.

Maternity and family planning

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

The department had systems for managing patients with complications. For example, if babies were born earlier than expected (at 26 weeks or earlier), they were transferred to another hospital which was able to provide the necessary care. This meant the service was responsive to the needs of newborn babies with complications.

Women told us that staff sought their views throughout their care. One person who was going to have a planned caesarean delivery told us how the midwives had made her feel very comfortable. They had given her a detailed explanation of what would happen before, during and after the delivery.

We found a patient staying in her own delivery suite. This ensured her privacy and dignity. This meant the service was responsive to women's individual needs.

Are maternity and family planning services well-led?

Staff told us that the department was well-led and that it had an open culture. There were also clear lines of accountability. Staff said that they were confident about their roles and responsibilities and that they received the necessary training and supervision to fulfil their role. They also said that the trust kept them well informed through the clinical governance newsletter and regular meetings. The department monitored staff attendance at mandatory training.

The department undertook appraisal of all members of staff annually. Midwifery supervisions were carried out regularly. For example, midwives from the community came regularly to the ward to update their skills and knowledge. There were also training plans for preceptors. The department had in place lunchtime education sessions that enabled sharing of knowledge. This showed that the service was well-led.

Children's care

Information about the service

The children's care team at Frimley Park Hospital NHS Foundation Trust provides inpatient services. The children's unit is a 26-bedded facility, covering surgical and acute admissions.

Summary of findings

Services were safe, caring and well-led. The department was well staffed and there were effective systems for identifying and learning from incidents. Parents we spoke with felt they were involved in the care of their children. The service was responsive to the needs of parents and the children.

Are children's care services safe?

The paediatric team monitored and minimised risks effectively. The Matron showed us a risk register and explained how staff used this to manage risks in the department. For example, following a review of incidents, the department had decided that it would have an on-call consultant present until 9pm during the week. The Matron also explained how safety alerts were received and shared within the department so that staff could take necessary action.

There were security doors and video cameras at the entrance to the ward. All medical and nursing staff wore an identity badge with their full name and position. There was also a large board that displayed photographs of the regular staff members who a child or relatives may meet during their stay on the ward.

Staff felt that the service was adequately staffed We spoke to three relatives who also said that they felt that the department was well staffed and that staff attended to their needs promptly. One person told us, "They [the nurses] were here as soon as you called for them." We spoke with the Matron and the Clinical Director, who confirmed that there was 24-hour junior doctor cover available for paediatric services. There was also consultant presence until 9pm every day, and after that the consultant who covered A&E also covered the paediatrics department. These arrangements ensured that children had access to appropriately skilled professionals at all times.

There were effective systems for identifying and learning from incidents. The Matron told us that they reported incidents on a regular basis and that there were opportunities to learn from incident reporting. We spoke to members of staff who confirmed that the department had an open and honest culture for reporting incidents. For example, one nurse told us how they had reported an incident of medicine being given late to a patient. An incident form was filled out and the staff nurse was provided with feedback on the incident. In that particular case, the staff nurse was informed that though the medicine was given late by 30 minutes, it was still within the NHS guidelines, which was 45 minutes, and the trust had an additional leeway of 30 minutes. We were told that the department would hold a one-to-one meeting with the staff member who reported the incident. Staff confirmed that they received feedback on reported incidents. This demonstrated that there were effective systems for identifying and learning from incidents.

Equipment was available to meet children's needs. Staff told us that the department always received the equipment it needed from the hospital's equipment replacement programme. We saw a copy of a recent order for new equipment costing the trust over £3,000. This was a new opti-flow meter to allow the monitoring of young babies' breathing. This demonstrated that equipment was available to meet the needs of children.

The Matron showed us how the department worked to decrease hospital infections. It had introduced standardised cleaning programmes across the department that had increased the number of cleaners from three to four people. We looked at the processes that were in place and found that there were appropriate cleaning systems to ensure the ward was clean and tidy. We also found the department to be clean and tidy. This demonstrated that cleaning systems were in place to maintain children's safety.

Children's care

Staff told us that they worked well with the safeguarding team locally. For example, they were alerted when children were admitted who were known to be at risk of abuse. They said that having the safeguarding teams located very close to the ward also enabled good working. Staff told us that they were trained in safeguarding children and knew how to raise an alert if they had any concerns about a child. We heard examples of good working with safeguarding teams, including regular visits to the wards. This demonstrated that good links with the hospital safeguarding team helped to maintain children's safety.

We checked emergency trolleys and found that they were appropriate for use in the event of a paediatric emergency. They were also regularly checked. However, there were instances where the people carrying out checks had not recorded them.

Are children's care services effective?

Parents told us they were able to stay with their children on the inpatient wards. There were five single rooms that could be used for children with high needs and their parents.

To ensure that children received effective care, referrals from GPs were received directly by the Paediatric Assessment Unit located on the ward. This facility was staffed by a paediatric nurse and a senior doctor. Three parents told us that direct referral provided them with assurance regarding their baby's wellbeing. We were told that 80% of the time, the children were discharged within an hour of being seen. If they required admission, it was generally for observations and for no more than 24 hours. This meant that staff provided children with appropriate and timely care and that parents were reassured about their child's care and treatment.

There were daily multi-disciplinary ward rounds, and staff showed us how parents and nurses were involved in these. Parents confirmed that they were involved in ward rounds with the doctors. They said that the ward rounds helped them to keep them informed about the progress their child was making. Doctors were able to answer their questions and the parents were able to get necessary support. This demonstrated that these services helped the care and treatment of the child.

The department used a paediatrics early warning score system to ensure the wellbeing of children. Members of staff we spoke with told us that the system was effective in identifying and escalating concerns.

The department had a number of clinical policies and procedures and we were shown how these guidelines had been developed in consultation with the paediatric dieticians and the practice development nurse.

Are children's care services caring?

We spoke with six parents whose children were being cared for on the ward. Five parents told us the care was excellent. One parent told us that staff were not as responsive to the needs of their child. We found that the child had been placed on material that could easily irritate their skin. When we showed this to the Matron, she immediately took action and ensured the item was removed.

We spoke with two children who told us that the nurses were very helpful and made them feel relaxed. We found that there were pain management policies in place and members of staff knew how to manage pain in children. One patient confirmed that they were asked regularly after their operation whether they had any pain. This demonstrated that members of staff provided the necessary medical support to manage pain in patients.

One parent told us that she was receiving training on how to give antibiotics to her child. She told us that the training was excellent. Parents told us that when they were with their child, access to food for themselves was difficult. We spoke about this concern with the Matron, who told us that arrangements were in place to provide support to parents on the wards. When we subsequently spoke to the parents, we found that the department had responded to these concerns.

Children's care

The department had kitchen facilities for parents, but they were underused because they did not have amenities such as tea or coffee. Parents said the sparseness of amenities meant that the facility was not useful for them. Furthermore, the kitchen was not close to the ward, and parents were reluctant to leave their children unattended. We shared these observations with the Matron, who said that there were plans to move the kitchen closer to the ward and provide parents with amenities.

The department also had a play specialist on the ward. A playroom was available to parents and their children. We spoke with one parent who told us that this provided a "break away from the ward" and was "greatly appreciated".

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

The Matron told us that the service received regular feedback and comments from parents and children on the wards. As mentioned previously, there were plans to move the kitchen closer to the ward as a result of feedback from parents. The shower facilities were also changed as a result of feedback from parents.

The ward had information on how parents and children could make complaints. Though the department rarely received any complaints, it had received a number of compliments from parents on the care provided to their children. This demonstrated that the service was responsive to people's needs.

Are children's care services well-led?

Staff told us that they were supported in their roles. They told us they had access to training programmes with other local units. We looked at the training records of six members of staff and found they were all up to date.

Staff also said that the department had an open and inclusive culture. Everyone we spoke with told us that they were happy working in the department. They told us that if they raised any concerns regarding patient care and safety, these were immediately addressed. All members of staff we spoke with had received appropriate supervision for their role. This showed that the service was well-led.

End of life care

Information about the service

The trust has a Palliative Care Steering Group that has developed policies and procedures to support end of life care at the hospital. During our visit we spoke with members of the palliative care and bereavement teams, the deputy chaplain and staff on wards and in the mortuary.

The hospital's palliative care team is available during normal working hours, and there are arrangements with the local hospice for support at weekends and evenings.

Over 50% of the patients supported by the palliative care team require non-cancer related end of life care. The team consists of a lead consultant, palliative care clinical nurse specialists and end of life care nurses, as well as a palliative care occupational therapist and a complimentary therapist.

Summary of findings

The trust provides a service that meets the needs of patients at the end of life, and their families. The palliative care team has a presence across the hospital and also provides outreach services and links with services in the community.

Are end of life care services safe?

The hospital had mechanisms in place to identify when patients required end of life care, involving a team of trained professionals and the patient and relatives, where possible. The hospital had recently reviewed and implemented updated guidelines for the care and support of end of life patients. Personalised nursing and medical care plans were in place, specifically for end of life care and we saw these were in use during our visit. End of life care plans included assessments of people's clinical, physical and social needs and preferences. A review of 11 patient records showed the palliative care team was involved in coordinating end of life care for patients and their families, and that care included consideration of patients' symptoms and management of their hydration, nutrition and pain. In addition, the hospital had introduced communication booklets to enable patients or families to write down questions or queries for staff to answer.

During our visit, ward staff told us that support from the palliative care team could be accessed when needed and that the team provided excellent advice and ward-based training. End of life care included guidance from specialists, for example on meeting people's dietary preferences and on how to provide safe support when moving people.

We found that the hospital records documenting decisions to not provide cardiopulmonary resuscitation (known as Do Not Attempt Cardiopulmonary Resuscitation or DNACPR forms) were not fully completed in six of 17 forms we reviewed. The decision-making processes were not clearly documented and there was no evidence that decisions had been reviewed when a patient's circumstances changed. It was not always clear whether staff had assessed patients' capacity to understand the decision. This meant a decision against resuscitation might be made without the involvement or knowledge of the patient or their next of kin.

We visited the mortuary and found there were opportunities to improve hygiene safety standards. The trust's Infection Control Committee had not informed or approved the cleaning and disinfection procedures, and we were concerned about the maintenance of the instrument disinfection equipment.

Are end of life care services effective?

The trust had implemented recognised clinical guidance for end of life care and monitored practices. For example, it had drafted a revised *Policy for the Dying, Deceased and Recently Bereaved*. It had issued new guidelines for the compassionate management of the dying patient following the removal of the Liverpool Care Pathway approach.

The trust results from the *National Care of the Dying Audit, 2011/2012* showed that it performed among the top 25% of hospitals for seven of the eight key measures relating to the quality of care. This audit considered, for example, the availability of patient information and policies relating to patient care as well as outcomes from clinical care. The trust had developed an action plan to promote further improvement. One notable area still for completion when we visited was the provision of seven-day working for the hospital palliative care team.

End of life care

The prescribing of medicines at the end of a patient's life was audited in October 2013. The results showed that this was carried out and documented safely and appropriately, particularly where the palliative care team had been involved. The last quarterly audit of the Liverpool Care Pathway was undertaken between January and March 2103, and reported in May 2013. The audit of the care pathway, for 20 patients who died at the hospital, identified areas of good practice, such as appropriate prescribing of medication and the involvement of relatives. Areas for improvement related primarily to the completion of documentation. The audit also showed that end of life care was provided for a range of diagnoses, and not primarily for cancer patients.

The trust has a policy available to all staff on resuscitation decisions and when not to undertake resuscitation. An audit of the DNACPR forms was carried out in 2012, and it showed that the trust had identified a need to improve communication with patients and provide more staff training. Our own findings showed that DNACPR forms did not always provide evidence that patients and their families had been involved in the decision-making process, which indicates this is an area that still requires further work.

We found there was a collaborative approach to providing end of life care, where staff aimed to provide a high standard of safe and compassionate care. The trust provided for people's religious and cultural preferences in end of life care, and the hospital chaplaincy was highly regarded by those we spoke with. The chaplaincy service was an integral part of the end of life team, and it olds memorial services at the hospital three times a year.

The bereavement team carried out the administration of deceased patients' documents and belongings. Its role was to provide practical advice, signposting relatives to support services such as the hospital chaplaincy service or community support groups. The service's information booklet is informative and available in different formats. However, the bereavement team's role did not include providing emotional support, and the office was open for limited hours during weekdays only. The team aimed to produce death certificates within 24 hours, and maintained information packs for site managers to access outside normal working hours.

Systems were in place within the mortuary to check that information about the deceased was correct and logged appropriately.

Are end of life care services caring?

Staff said that end of life care was sensitive and caring. We were unable to talk with people receiving the service during our visit. We spoke with two junior doctors on different wards, who had observed that end of life care was provided in a dignified and considerate manner.

In 2012, the hospital surveyed patients' relatives for their views on the palliative care service, and obtained eight responses. The feedback was positive, with relatives reporting that they were either satisfied or very satisfied with the palliative care team. During our visit we observed that a consultant met with a patient and their family, with the support of the specialist palliative care nurse, to discuss end of life care. This was carried out with discretion and in private.

The chaplaincy service supported people's spiritual and religious needs, and the chaplain we spoke with had undertaken training in palliative care as well as dementia care to help inform his role. Hospital chaplains provided 24-hour spiritual care, and the chapel and multi-faith room were open for people of all faiths, or none, at all times. The chaplaincy *Guide to Religious and Cultural Beliefs* included information on different cultural and religious end of life requirements and preferences to accommodate people's specific needs. We found examples of how the service had supported people of different religions and cultures at the end of life. We also noted that a mortuary technician had been awarded a certificate of achievement by the trust for their professionalism, care and respect in ensuring Islamic religious traditions had been upheld. This showed that the hospital was sensitive to people's specific cultural needs. The hospital also invited relatives of patients who had died at the hospital to attend memorial services annually. These memorial services took place in the hospital chapel, which extended compassion to grieving families.

The hospital maintained a 'Time Garden' for the exclusive use of patients and families during end of life care. This was a landscaped garden with a dedicated garden room. People could use this area to spend time away from the hospital environment. The time garden had also been used for marriage services.

End of life care

The information leaflets for people at different stages of end of life care were written in a clear yet sympathetic way. We were told that about 90 senior nurses had completed a course in enhanced communication skills, to help them talk with patients and families about topics such as end of life.

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

The palliative care team visited end of life care patients daily during the working week, and had emergency cover arrangements with the local hospice for weekends and evenings. We were told that a seven-day service was under consideration at the time of our visit. The team had established a simple referral system, which meant that referrals could be made at any time of the day or night. Ward staff confirmed that the referral process was straightforward and that the palliative care team was responsive and had a daily presence when end of life patients were on their wards.

The service engaged with local GPs. We spoke with a trainee GP who was seconded to the hospital's palliative care team on a part-time arrangement. He commented that he was well supported by the team and valued the experience he was gaining, which he would be able to take back into the community. This arrangement enabled trainee GPs to learn about this complex medical specialty and improve communication skills.

We saw that the trust had received and responded to complaints relating to end of life care. For example, it had developed a revised protocol to prioritise the provision of side rooms for people at the end of their life. This was carried out to ensure patients and their families could have more privacy and dignity. The revised protocol had been agreed with the infection control and bed management teams. However, during our visit we found some staff nurses were not aware of this protocol, which meant people would not necessarily be offered a side room for end of life care.

Are end of life care services well-led?

The trust's end of life steering group was well staffed, with people who demonstrated an interest and passion for their role. This was a multi-professional group which engaged with professionals in the community, including the local hospice and GP services. Members of the group said they were well supported and we saw examples of the impact the group had made in improving the service in response to feedback and complaints. Audits had been carried out which demonstrated the service was effective, listened to people's experiences and sought to make improvements.

Outpatients

Information about the service

Frimley Park Hospital provides a wide range of outpatient services. There are nine outpatient areas with their own reception and waiting areas. The cardiac centre and the children's outpatient departments are located inside the main body of the hospital. During our visit we spoke with nine members of staff, including administrators, healthcare assistants, nursing and medical staff. We also spoke with four patients and a volunteer driver on site, and with other patients during our open listening event.

Summary of findings

In outpatients, people received care that was effective and safe. The waiting areas were clean and well organised, with separate outpatient areas for children. Systems were in place to organise clinics effectively. However, we found that appointments were sometimes double-booked. This was because although the service had expanded, with additional doctors and support staff to deliver extended clinics, the demand for outpatient services had increased. Information was on display showing patients if appointments were delayed. Staff were responsive, and were able to guide and support patients at all times.

Are outpatients services safe?

Outpatient services were provided in clean and well organised premises. Housekeeping staff maintained the cleanliness of the environment, with support from healthcare assistants, and we saw that cleaning schedules were signed and up to date.

Children were seen in a dedicated children's outpatient department. In the department there were separate waiting areas for children aged under 11years and for older children, which helped keep children safe. The staff member on duty could outline steps they would take if they had concerns about child abuse. However, the guidance documentation was not available in the department for reference. Staff reported that they had completed training in children's safeguarding.

We saw that patient information was managed safely, and records were not left unattended in the outpatient areas.

Resuscitation equipment was checked and new resuscitation equipment had been introduced into the children's outpatient department. This had been implemented to standardise safety equipment for children's services.

In the X-ray department we found that systems were in place to check patient identity and to keep people safe. The trust audited practices to ensure they were delivered to recognised standards.

Are outpatients services effective?

Patients were generally complimentary about the quality of outpatient care. The cardiac clinic was highly regarded by the patients we spoke with. They valued the 'one shot service', which meant they were well informed about their care and were able to ask questions. The cardiac centre was well equipped with cardiac test equipment and was staffed by military technicians as well as those employed directly by the trust.

One person receiving cancer care told us that they felt they could ask questions and that they were satisfied with the answers provided. They commented that medical treatment was good but that they would appreciate more emotional support as part of their package of care. They felt this was an area the trust was not adequately providing.

Relatives of patients at the children's outpatient service were positive about the quality of treatment the children received. Children had access to specialist clinics, including diabetic clinics.

Systems were in place to audit practices in the X-ray department to ensure they were safe and effective. We saw that the trust monitored training attendance and that staff meetings were held on a monthly basis. Staff commented that learning was shared at these meetings, for instance from complaints or incidents. Most complaints related to delays in appointments and action had been taken to alleviate the issues.

Outpatients

Are outpatients services caring?

We saw that staff engaged with patients in a friendly and compassionate way. Patients we spoke with said they felt cared for.

Healthcare assistants were assigned to support each clinic, and they were able to signpost patients to relevant information. The electronic information screens in waiting areas showed any delays in appointments, but the healthcare assistants also explained delays in person. Staff said this approach was effective in providing personalised care and reassurance.

Results of the Cancer Patient Experience Survey 2012/13 showed that this hospital scored in the top 20% of trusts for 25 of the 69 questions asked. Most responses were similar to those of other trusts. The areas where the trust performed worse than most other trusts related to communication, research activity and asking patients what name they preferred to be called.

We noted that 2013 patient satisfaction survey results showed the service scored well for privacy, time to care and providing explanations of treatment. Managers had attended customer care training and we saw that staff were prompt to respond to people if they appeared to need assistance in any way.

Are outpatients services responsive to people's needs?

The outpatients departments were calm and organised. Healthcare assistants supported each clinic, and we saw that staff checked in people at reception efficiently. A pilot scheme was in place for patients to check in using a touch-screen terminal if they preferred, and staff were on hand to provide guidance. We saw that when people had particular needs on arrival at the department, staff responded promptly to provide additional guidance and support. When we visited, the waiting areas were not over-crowded and there were sufficient seats for people. We were told, however, that cancer clinics were particularly busy and that waiting times increased on those days.

Data for the trust shows that waiting times for outpatient appointments were within the expected range.

Staff told us that the demand for outpatient services had increased over the past year and that the trust had reorganised clinics to provide extended clinic times and had recruited additional medical staff. However, we still found that the clinics were often overbooked. For example, at one plastic surgery clinic, on three occasions two or three patients had been booked onto the same 15-minute appointment time. This meant patients would sometimes wait longer than they anticipated for their appointment. The volunteer driver we spoke with confirmed this, saying that patients visiting outpatients at this hospital waited longer than at the other hospitals where they volunteered. They said patients complained about the administration of the service. However, this was not raised as an issue for the cardiac clinic, where we did not find examples of double-booked appointments.

There were issues with access to outpatient clinics. The volunteer driver commented that the hospital did not provide parking spaces near the entrance for volunteer drivers, or wheelchairs for them to take their clients to clinics. Although the cardiac clinic was highly regarded by the patients we spoke with, we noted that some people had difficulty finding it. This service was not located near the main entrance, and we noticed that one person needed help to find their way there. The hospital had responded to this issue by assigning a dedicated porter to the service. However, we saw that other staff were also called on to provide this role.

Information was available for patients in different formats. The pilot automatic check-in terminals had information in over 10 different languages. Staff said that referral information usually included any particular communication needs, but if patients arrived needing language assistance (for example with sign language), this could be provided on request. One staff member told us that access to interpreters was difficult. The service had appointed a link nurse for disabilities, and this person had attended training and group work in this topic, to support access for people with disabilities.

Outpatients

Are outpatients services well-led?

Staff told us that they were well supported in their role and that their views were listened to at staff meetings and appraisals. One consultant said they felt "very valued" and were "well-led by the executive team". The outpatient department was managed by staff who understood their roles and worked well as a team. Staff told us they enjoyed working in the department and had good access to training. They reported that the training programme was excellent and that staff were encouraged to develop their skills. The hospital provided staff forums where staff were able to meet with the executive team and raise issues.

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice:

- An emphasis on teamwork in A&E. The department was headed by a clinical director and a matron. Staff told us that the management team was open and approachable and that it provided good leadership. Staff said that this openness provided them with the confidence to challenge poor practice and raise concerns. Staff said that they had confidence in the management team and felt that any issues or concerns would be addressed in a timely fashion. Overall, staff told us they were proud to work for the hospital. The team appeared to be efficient and the concept of teamwork seemed to be evident within the department.
- An open culture of learning from incidents and accidents in the areas of the trust visited.
- End of life care.
- Junior doctor support and education.
- A highly visible and outstanding leadership team.
- A number of warm and sensitive interactions between staff and patients.

Areas for improvement

Action the hospital MUST take to improve

None

Other areas where the trust could improve

- Ensure that the patient records generated in A&E are readily available and in a format which is accessible for other hospital departments.
- Improve the accessibility of specialist mental health care practitioners out of hours, especially for people using A&E.
- Continue to implement plans to improve care for people living with dementia.
- The mortuary leadership needs to take opportunities to improve hygiene safety standards.
- Do not attempt cardiopulmonary resuscitation forms with in-patient records need to be reviewed to ensure they are completed and up to date.

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Frimley Park Hospital NHS
NHS Foundation Trust

Update report for the proposed acquisition of
Heatherwood and Wexham Park Hospitals NHS Foundation Trust by
Frimley Park NHS Foundation Trust

Author: Jane Hogg, Integration Director
Date: June 2014

PURPOSE

The purpose of the paper is to provide the Bracknell Forest Health Overview and Scrutiny Committee with an update on progress towards a possible acquisition of Heatherwood and Wexham Park NHS Foundation Trust by Frimley Park NHS Foundation Trust. The transaction timeline is challenging and many elements are subject to change, but this paper gives a report of the state of play in mid June 2014.

TIMELINE

- 2012/2013 – HWPH concludes they are unsustainable as a stand alone business. McKinsey report for Berkshire East commissioners concludes acquisition by FPH as a sustainable solution for HWPH
- April 2013 – OBC for the acquisition of HWP by FPH developed for FPH
- August 2013 – review by FPH board of OBC and conclusion to consider proceeding to FBC
- October 2013 to January 2014 – support from central bodies for consideration of the FBC
- February 2014 – FPH board decides to proceed to FBC
- March 2014 – submission of case to Competition and Markets Authority (formerly Office of Fair Trading)
- 1 May 2014 – Care Quality Commission releases inspection report rating HWPH as 'inadequate' and HWPH is placed in special measures by Monitor on 3 May
- 14 May 2014 – CMA clears the proposed acquisition
- Summer 2014 – proposals reviewed by boards and councils of governors of each hospital, and by Monitor the foundation trust regulator, who must approve the transaction

BACKGROUND AND CASE FOR CHANGE

HWPH is currently facing significant financial, operational & clinical challenges. In the absence of the transaction, ongoing financial and operational challenges may risk FPH's sustainability in the medium term

- **Increasing financial and operational pressures** are being placed on acute Trusts. FPH is facing declining surpluses over the coming years and HWPH is in a continuing unsustainable financial position
- **There is a continued drive for high quality sustainable care in the NHS**. FPH is at risk of becoming clinically subscale in certain areas as the NHS consolidates to preserve and improve quality care. HWPH already has areas of poor quality in patient care and has lost certain services
- **FPH and HWPH are facing a growing and ageing population**, coupled with a forecast increase in chronic diseases, which will put additional strain on local services
- **The combined organisation provides the opportunity to achieve critical mass in clinical services** and achieve a sustainable financial position
- **Options appraisal has shown that acquisition offers the best opportunity for FPH** to maintain medium term sustainability at the current time
- **An Outline Business Case for the transaction was approved by the FPH Board in August 2013 and reviewed by Monitor in October 2013.** The FPH Board decided to proceed with a Full Business Case for the acquisition in February 2014

NATIONAL HEALTH CONTEXT

The national context breaks down into four areas which drive the rationale for the acquisition of HWPH.

- **Ongoing financial challenge.** NHS Trusts throughout England are required to deliver efficiency savings of circa 4-5% per annum. Increasingly it is recognised traditional CIP schemes alone will no longer deliver the required savings. Trusts will be expected to engage in wider transformational change and service reconfiguration with other agencies and providers in order to deliver the productivity improvements required.

- **Increasing operational pressures.** Trusts across England are encountering increasing demand for acute services, particularly through escalating ED attendances and unplanned admissions to hospital. Additionally, an ageing population with associated long-term conditions will demand more from health care providers year on year.

- **Increasing quality expectations.** There is ever increasing scrutiny of Trusts, hospitals, departments and individual healthcare professionals. Rolling CQC inspections, the Francis report, and more recently the Keogh Review, are increasing pressure to maintain high standards of care at all times, requiring changes to health service culture and working practices in the context of a constrained funding environment.

- **Doubts over the sustainability of smaller acute Trusts.** A series of reviews and guidance[1,2] have recommended that increased specialisation of clinical teams serving larger populations deliver improved outcomes for patients. Another challenge for smaller Trusts is sustaining services as primary care and specialist secondary care providers increase market share. Additionally the recent report by Monitor on the performance of the Foundation Trust sector for the year ended 31 March shows, that out of 18 failing acute Trusts, 16 are small to medium (that is, have an income up to £400m).

LOCAL HEALTH ECONOMY CONTEXT

At a local level, health services will need to respond to anticipated changes in the demographic and health profile of the local population. Local councils have drawn up Joint Strategic Needs Assessments (JSNA) which identify some common themes that drive the health needs of the local populations. These are:

- **Population growth:** The population is expected to grow by a total of 3.3% between 2013 and 2018.
- **Ageing population:** Growth in the 75+ age group is forecast to be a total of 11.6% between 2013 and 2018. This is significant since more than 70% of people aged 75+ have one or more long term condition. The average person aged 85+ makes three times as many visits to primary care and is 14 times more likely to be admitted to hospital than the average 15-39 year old.
- **Levels of deprivation:** The FPH and HWPH catchment populations in general have low levels of deprivation. However, there are pockets of deprivation within the catchment area, such as parts of Camberley, Aldershot and particularly in Slough. Typically less affluent areas will have a disease profile that is more associated with deprivation such as respiratory disease and diabetes. Comparatively, the more affluent areas have a higher life expectancy, but face the associated disease and need for long term care that comes with an ageing population.
- **Health profiles:** Cardio-vascular disease is the leading cause of death in both males and females across the catchment area. The incidence of chronic conditions is expected to increase over the coming years, stroke continues to increase nationally, and dementia is predicted to increase by over 50% in the next 15 years.

All of the above means that there will be significantly more operational pressures over the coming years on both Trusts. Improved care of the elderly services and implementation of integrated models of care are key to reducing unplanned hospital admissions.

TRUST OVERVIEWS

Frimley Park Hospital NHS Foundation Trust is a district general hospital located in Surrey, close to the Hampshire and Berkshire borders. The Trust provides a full-range of district general hospital services for the population of North East Hampshire and West Surrey. The catchment population has grown significantly from 170,000 in 1974 when the hospital was built to between 400,000 and 500,000 today and this figure is expected to grow further.

[1] *"Is volume related to outcome in healthcare? A systematic review and methodological critique of the literature"*, Ann. Intern. Med. 137: 511 – 520 Halm et al, 2002
[2] *Hospital volume and health care outcomes, costs and patient access* ,NHS Centre for Reviews and Dissemination, systemic review 1996

Heatherwood and Wexham Park Hospital Foundation Trust serves a population of between 400,000 and 500,000 people from the areas of Ascot, Bracknell, Maidenhead, Slough, Windsor and south Buckinghamshire. The Trust delivers a wide range of healthcare services from two main sites; Heatherwood Hospital in Ascot opened in 1923, and Wexham Park Hospital in Slough opened in 1968.

FPH AND HWPH DRIVERS FOR CHANGE

The specific imperatives for change for both FPH and HWPH are outlined below:

FPH Hospital Drivers for Change

FPH is facing declining operating surpluses over the coming years, the consequence of annual efficiency targets and increasing clinical and demographic pressures affecting commissioners. The FPH leadership anticipate a real threat to the sustainability of patient services unless a fundamental strategic change takes place.

The leadership team consider the Trust is too small to meet the following future challenges:

- **Clinical:** FPH is at risk of becoming sub-scale as the NHS consolidates into fewer larger Trusts and hence losing services and income over the medium term. NHS England has outlined specialised services provided in centres of excellence as one of their key priorities for Trusts going forward[3].

  The implications of this are that there will be fewer specialist service providers with larger market shares. For FPH specifically, there is a risk of services being lost and volumes being reduced as specialist secondary providers increase market share in response to this.

  FPH also wishes to maintain its current position as a centre of excellence, able to attract and retain the right high quality staff to maintain and improve services for its patients.

- **Financial sustainability:** In light of the scale point above FPH is forecast to suffer from declining surpluses from FY2014/15 onwards. Additionally FPH will find it increasingly difficult to meet the annual circa 4-5% efficiency requirement placed on Trusts, and will face pressure from a shift to move care into the community and a virtually flat funding settlement for the NHS anticipated over the next few years.

Heatherwood and Wexham Park Hospital Drivers for Change

HWPH is at present not financially sustainable and requires significant recurrent financial support and there is an acknowledged requirement to improve governance throughout the organisation. The Trust has been in breach of the terms of its authorisation since 2009 and continues to exist with a significant financial deficit. The Trust has struggled financially since 2009, with a deficit position in 2012/13 of £15.3m. In addition, Monitor announced the Trust had been placed in special measures in May 2014. As part of this process FPH has been invited to 'buddy' with HWPH.

Several attempts have been made to build a viable future, however, the HWPH board in January 2012 recognised that its position as a standalone organisation was unsustainable, chiefly due to the level of capital investment required to provide quality facilities.

The following challenges have been identified:

- **Clinical/ Financial Scale:** The board of HWPH has recognised that in its current position it is unsustainable and sub-scale, having already lost certain services including hyper-acute stroke; the 24/7 PCI service and Level 2+ neonatal care.
- **Patient Care:** HWPH had a red rating recorded on Oct, 2013 – the lowest governance rating since July 2009. The Care Quality Commission (CQC) found serious clinical failings at the Trust during its inspections over the course of 2013 and in a more recent inspection carried out in February 2014. The overall and most recent CQC findings of the Trust were rated as inadequate with a question continuing over its future sustainability. A total

[3] NHS England 5 year planning strategy document 2014/15 – 2018/19

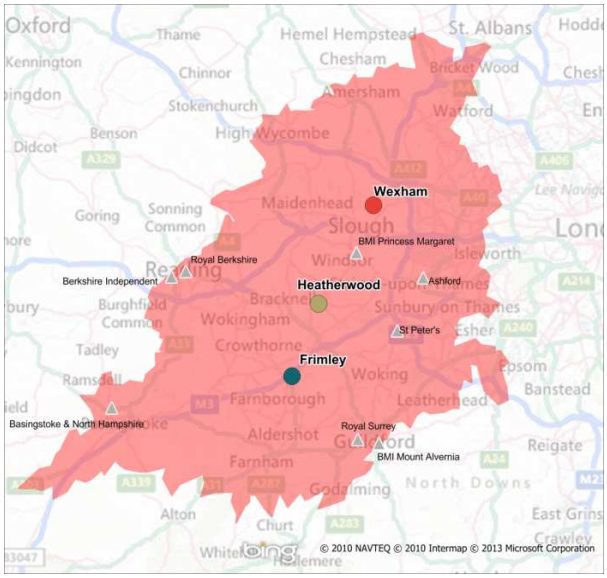
of twenty four actions were recommended – eighteen as 'must' happen and six as 'should' happen. On 3 May 2014 Monitor announced HWPH had been placed in special measures.[4]

- **Financial sustainability:** The Trust has been in breach of the terms of its authorisation since 2009, and it continues to have a significant financial deficit, and is unable to deliver the necessary capital expenditure to improve the Wexham Park site. It has been classified by Monitor as having a FRR (Financial Risk Rating) of 1 (the lowest rating) since 2009 and now has a CSRR (Continuity of Service Risk Rating) of 2.
- **Governance:** The Trust has been classified by Monitor as a poor performer against its peers for governance standards, scoring a red rating since 2009. Despite several changes of leadership since the Trust was declared in breach of its Terms of Authorisation by Monitor, none have succeeded in resolving the issue. On 3 May 2014, Monitor announced the Trust had been placed in special measures.
- **Human Resources**: The Trust is also facing short-term challenges in providing increased Consultant-led service provision and managing with reduced numbers of junior doctors; while endeavouring to meet the surgical safety thresholds. For example, the new guidance on acute colorectal surgery and increased demand for specialised on-call rotas. It is also struggling to recruit staff, having high levels of agency staff across clinical and non-clinical areas.

OPPORTUNITIES AS A COMBINED ORGANISATION

The acquisition of HWPH by FPH and the resulting increased population served of between 800,000 and 1,000,000 people will create the organisational scale necessary to establish robust, sustainable services for the people of Berkshire, Buckinghamshire, North East Hampshire and Surrey. The current geographic reach of the two Trusts is shown in Figure 1 below and is based on referral patterns and distance to the hospital sites. Figure 1 below shows a 30 minute drive time, and captures around 90% of all the GP referrals to both current Trusts.

Figure 1: Area of the enlarged Trust capturing circa. 90% of GP referrals to the two current Trusts



The acquisition will enable a platform for change, driving forward clinical service changes where appropriate and providing the impetus to create new services to serve the growing and ageing population. The enlarged trust will be better placed to recruit and retain high quality clinical staff and to offer excellent training opportunities. Back-office and operational consolidation will help release resources for front-line services.

The enlarged organisation will benefit from a unique opportunity to focus finances, resources, expertise and equipment to better serve patients. It will provide the capacity and impetus to review and improve delivery models.

[4] FPH has entered into a buddying arrangement with HWP as part of Monitor's processes to provide support to them while they are in special measures. Should the transaction go ahead, this special measures arrangement would cease. It is separate from the preparations towards a potential acquisition.

VISION FOR THE NEW ORGANISATION

"United in the pursuit of the goal of continuous improvement and the ambition and passion to be the country's best"

- **The enlarged Trust will focus upon developing strong clinical leadership** across all sites, supported by a Board of the minimum size necessary to effectively manage the organisation
- **Effective values**, well established at FPH, will be promoted across all sites
- **A streamlined centralised back office function** will be implemented where possible
- **An integration plan and organisational development strategy have been developed** to support the acquisition.

Delivering the highest quality services for all patients remains the paramount aim for the FPH leadership team. In bringing together Heatherwood, Wexham Park and Frimley Park hospitals, the clinical and managerial leadership aim to deliver an organisation that provides service improvements and long-term benefits for patients and staff across the four counties of Berkshire, Buckinghamshire, Hampshire, Surrey and beyond. A key indicator of success will be the three sites operating together, genuinely integrated as if a single hospital unit.

The FPH management have successfully embedded their vision and principles among the staff through significant communication activities and leadership engagement. Following the acquisition, the executive team will lead the engagement work with teams, explain the imperative for change and cascade a single set of core values across all sites through the local management teams and face to face meetings with the Executives.

PROPOSED CLINICAL VISION

FPH has consistently delivered high standards of clinical quality and patient experience while HWPH is facing a number of clinical quality challenges that have been reported by both the CQC and FPH's clinical due diligence. The enlarged organisation will address these comprehensively.

- The proposed clinical model will bring the following improvements across the enlarged Trust:
  1. **Improve the quality at HWPH** through a common culture based on FPH leadership through robust clinical governance
  2. **Improve existing services and develop new services** for patients based on sharing expertise and developing improved interfaces with community healthcare and the scale of the new organisation will allow for greater subspecialisation
  3. **Provide a new model of elective care including a new centre of excellence** for elective care at Heatherwood and enhanced patient centred models of care e.g. 'one stop shop' services.
- **Implementation will be carried out in a way that clinical quality is maintained and improved at all three site**s throughout the transformation

It is widely recognised that HWPH is facing a number of challenges in clinical quality. These have been demonstrated in an ongoing challenge in delivery of national quality indicators such as the 4 hour Emergency Department target and the 18 week RTT target for elective patients. A number of patient experience measures including the Friends and Family measure and annual patient survey indicate that patients are not happy with the delivery of service. The Friends and Family Test results are poor, particularly in A&E, with a national promoter score of 23 in December 2013 against a national average of 56.

Members of the public expressed their concern to the CQC regarding poor care and loss of privacy and dignity that they and their relatives experienced following treatment at the Trust. The most detailed CQC inspection recommended 24 actions, 18 as 'must happen' priorities.

FPH has consistently delivered a financial risk rating of 4 or above[5] and has won a series of awards[6] for high standards of clinical quality and patient experience. This is supported by a stable management structure that has demonstrated its ability to deliver over a number of years. The acquisition provides a way forward to improve services for both organisations, ensure equity of services and parity of access for the population served by HWPH and FPH. The proposed clinical model will bring the following specific benefits:

1. **Improve the quality at HWPH** through a common culture based on FPH leadership through robust clinical governance
2. **Improving existing services and developing new services for patients** based on sharing expertise and developing improved interfaces with community healthcare. The scale of the new organisation will allow for greater subspecialisation.
3. **New model of elective care** including a new centre of excellence for elective care at Heatherwood and enhanced patient centred models of care e.g. 'one stop shop' services

Key specific changes envisaged within the proposed clinical model include:

- Changes in care of the elderly (CoE): proactive management of higher risk patients, provision of front-door CoE physicians, and greater integration with local health providers will create treatment pathways specifically for older adults and lead to both improved hospital care and early supported discharge;
- Changes in the ED model: excellent quality of care (in all 5 quality indicators) will be achieved through streamlined patient flows, 24/7 Consultant-delivered care, and closer integration with community services;
- One site to gain major emergency status
- The intention to deliver a hyper acute stroke unit (HASU) and pPCI at HWPH; and
- Changes in the urology and cancer networks to ensure that more local services are available for patients, including access to highly specialised services where possible.

Overall, the acquisition will significantly improve patient care across the catchment areas of FPH and HWPH. Bringing together two Trusts with important complementarities will deliver improved clinical outcomes through larger clinical teams and improved access to services for patients. The ability to attract and retain high quality staff will support the delivery of these benefits.

Implementation of the clinical model will be carried out to ensure that the existing excellent quality of services is maintained or enhanced, new services are developed and the clinical pathways are transformed over a pragmatic timeline so that senior leaders are able to devote adequate time to the integration. The focus will therefore be on delivering the short-term changes to 'business as usual' that address current clinical issues and preparing the medium- and long-term changes that will drive patient benefits.

This structured approach to stabilising and improving the delivery of services to patients will allow for services to be developed and delivered in appropriately planned ways, with good co-ordination between health and social care providers across the health communities. While HWPH is in an unstable position with an uncertain future, some patients are choosing to go to other parts of the health system in a less planned way, in some cases leading to pressure on services and difficulties in providing the appropriate capacity across the whole system.

The clinical model assumes that the mix of services currently offered to patients in their local area will remain locally. The clinical model is actually proposing that more services which have been lost from the HWPH sites be returned to be provided more locally on those core sites. This should become possible, with commissioner support, as the quality and financial stability of the enlarged organisation is delivered. Should the enlarged organisation wish to make any substantial service changes in the future, it would follow an appropriate process of involving all local stakeholders in shaping plans and giving formal feedback on those plans.

[5]Frimley Park Hospital NHS FT annual reports. Financial Risk Ratings of NHS Foundation Trusts:http://www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/he-0

[6] Baby Friendly full accreditation (UNICEF); CHKS Top 40 Hospital (awarded for 10 consecutive years); MHP Health Mandate Quality Index Top five acute trust 2013;NHS Staff Survey: Best acute trust in the country for staff engagement (2013);NHS Staff Survey: Best place to work (acute Trusts in England, 2012);NHS Staff Survey: Best job satisfaction of an acute trust (2011);Cancer patient experience survey top 20% of all Trusts (2012/2013);First chemo department to be adopted by McMillan Cancer Care

ENGAGEMENT PROCESS

Commissioner engagement

A commissioner engagement process has been undertaken, with local and national bodies, to elicit commissioners' views on the transaction and to work through and agree the key principles and finances underpinning it. The Chief Executive and the Medical Director of FPH have attended public CCG meetings to discuss the process of potential acquisition, the drivers for change and the process by which the clinical model has been discussed so far. Clinicians from HWPH and FPH have met on a specialty by specialty basis to discuss opportunities presented by an integrated organisation. Each area has met at least three times. There has also been a meeting with senior clinical leaders in CCGs to discuss and review emerging ideas for clinical services and future improvements in quality and service delivery.

This engagement process is ongoing. High level outcomes include:

- Supportive of plans to improve the elderly care services, including greater integration with community providers
- Supportive of improvements to the HWPH ED to reduce non-elective activity
- Majority supportive of an elective facility being developed at Heatherwood
- Comparison of baseline activity and financial assumptions has shown that there is a strong alignment on the overall forward assumptions for the enlarged Trust, but some difference in starting positions
- Several potential opportunities for repatriation of work such as Obstetrics and Ophthalmology have been identified.

Public and patient engagement

FPH has been discussing the proposed acquisition with its members, public and patients and the Council of Governors at Council of Governor meetings and at local constituency meetings. The core programme of health events held through the Trust's community includes a dedicated section outlining the Trust vision. These events are typically well attended with 100 to 200 guests.

At each meeting the reasons for considering this acquisition are presented and those attending are encouraged to ask questions and provide feedback. Across the range of meetings that have been undertaken so far, the majority of those present understand the reasons why FPH wants to consider the acquisition.

Public statements about the progress of the acquisition process continue to be shared with local media as appropriate. The Trust plans to utilise its strong and active social media community to engage the public as acquisition approaches.

Phased approach to engagement

FPH is taking a phased approach to engagement as the nature of engagement, messages and stakeholder impacts will change through pre-acquisition, integration and transformation.

CONCLUSION

We are very much aware of the complex issues at Heatherwood and Wexham Park Hospitals NHS Foundation Trust. In supporting HWPH through a buddying process we will do all we can to help lift the trust's performance and improve services for local people, while continuing to explore the potential acquisition of HWPH.

The board at Frimley Park Hospital NHS Foundation Trust continues to work on a full business case examining the prospects of the acquisition in great detail. This stage is due to be finished by the summer. Once completed, the full business case will form the basis of the case made to each trust's board and council of governors and to Monitor, the foundation trust regulator, in seeking their agreement for the acquisition to proceed.

The acquisition has been assessed and cleared by the Competition and Markets Authority, whose review was completed in mid-May 2014.

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
3 JULY 2014

THE PATIENTS' EXPERIENCE
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to review: the latest inpatient survey results for the three hospital trusts, also the current information from the NHS Choices website, for the NHS Foundation Trusts providing most secondary NHS services to Bracknell Forest residents.

2 RECOMMENDATION

That the Health Overview and Scrutiny Panel:

2.1 Considers the results of the adult inpatient surveys for Frimley Park, Heatherwood & Wexham Park, and Royal Berkshire hospitals Trusts, attached.

2.2 Considers the NHS Choices information concerning the nearby NHS Trusts, at Appendix 1.

2.3 Receives the views of the Bracknell and Ascot Clinical Commissioning Group on the quality of patient care at Frimley Park, Royal Berkshire and Heatherwood & Wexham Park Hospitals NHS Foundation Trusts.

2.4 Determines whether to make any further enquiries based on the surveys and NHS Choices information.

3 SUPPORTING INFORMATION

3.1 The Health O&S Panel has previously decided to obtain direct knowledge of the service user's perspective of public services, through a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents. This is to include inpatient survey results and the NHS Choices information.

NHS Choices Website

3.2 NHS Choices (www.nhs.uk) is the UK's biggest health website. It provides a comprehensive health information service, including more than 20,000 regularly updated articles. There are also hundreds of thousands of entries in more than 50 directories that can be used to find, choose and compare health services in England.

The site draws together the knowledge and expertise of:

- NHS Evidence, formerly the National Library for Health
- the Health and Social Care Information Centre (HSCIC)
- the Care Quality Commission (CQC)
- many other health and social care organisations

ALTERNATIVE OPTIONS CONSIDERED/ ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS/ EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / OTHER OFFICERS/ CONSULTATION – Not applicable

Contact for further information

Richard Beaumont – 01344 352283
e-mail: richard.beaumont@bracknell-forest.gov.uk

Appendix 1

	NHS Choices users rating	Care Quality Commission national standards	Recommended by staff	Responding to patient safety alerts	Mortality rate
	i	i	i	i	i
Royal Berkshire Bracknell Clinic					Add to shortlist
Tel: 01344 662 900 Eastern Gate Brants Bridge Bracknell Berkshire RG12 9BG **0.79 miles away** | Get directions	9 ratings Rate it yourself	**n/a** Data not available	73 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (1.0624)
Heatherwood Hospital					Add to shortlist
Tel: 01344 623 333 London Road Ascot Berkshire SL5 8AA **2.91 miles away** | Get directions	25 ratings Rate it yourself	Some standards not met Visit CQC profile	51 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (0.9648)

	NHS Choices users rating	Care Quality Commission national standards	Recommended by staff	Responding to patient safety alerts	Mortality rate
	i	i	i	i	i
Frimley Park Hospital					☐ Add to shortlist
Tel: 01276604604 Portsmouth Road Camberley Surrey GU16 7UJ 6.68 miles away | Get directions P	175 ratings Rate it yourself	All standards met Visit CQC profile	84 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (0.9281)
King Edward Vii Hospital					☐ Add to shortlist
Tel: 01753 860 441 St Leonards Road Windsor Berkshire SL4 3DP 7.21 miles away | Get directions P	No ratings yet Rate it yourself	All standards met Visit CQC profile	73 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (1.0624)

	NHS Choices users rating	Care Quality Commission national standards	Recommended by staff	Responding to patient safety alerts	Mortality rate
	i	i	i	i	i

St Marks Hospital — Add to shortlist

Tel: 01628 632012 St Mark's Road Maidenhead Berkshire Berkshire SL6 6DU 7.53 miles away | Get directions	15 ratings Rate it yourself	All standards met Visit CQC profile	64 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	n/a Data not available

Royal Berkshire Hospital — Add to shortlist

Tel: 0118 322 5111 London Road Reading Berkshire RG1 5AN 9.17 miles away | Get directions	202 ratings Rate it yourself	All standards met Visit CQC profile	73 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (1.0624)

NHS Choices users rating	Care Quality Commission national standards	Recommended by staff	Responding to patient safety alerts	Mortality rate
i	i	i	i	i

Wexham Park Hospital — Add to shortlist

Tel: 01753 633000
Wexham Street
Slough
Berkshire
SL2 4HL
11.19 miles away | Get directions

142 ratings
Rate it yourself

Enforcement action in progress Visit CQC profile

51
% of staff who would recommend this organisation

Good - All alerts signed off where deadline has passed

OK
As expected in hospital and up to 30 days after discharge (0.9648)

Prospect Park Hospital

Telephone: 0118 960 5000
Address: Honey End Lane, Tilehurst, Reading, Berkshire, RG30 4EJ

24 ratings
More information about NHS Choices user ratings

Some standards not met
Visit CQC profile

Good - All alerts signed off where deadline has passed

Explanatory Notes

NHS Choices User Ratings

The proportion of the people who rated this hospital on NHS Choices who would recommend the organisation's services to a friend.

Care Quality Commission National Standards

As the independent regulator for health and adult social care in England, CQC check whether services are meeting their national standards of quality and safety.

Recommended by Staff

This measure shows whether staff agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by the trust. The results are taken from the 2010 national NHS staff survey.

Responding to Patient Safety Alerts

Whether an NHS organisation is signing off its response to patient safety alerts that are issued by the National Patient Safety Agency. The 'Poor' category shows that the organisations has not signed off as complete **one or more** safety alerts for which the deadline has passed, the 'Good' category shows that the organisation has signed off **all** alerts for which the deadline has passed.

Mortality Rate

Whether the rate of deaths for an NHS Trust is better or worse than expected for the Trust based on the type of cases treated. The adjusted mortality ratio reflects deaths in hospital and within 30 days of discharge.

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Patient survey report 2013

Survey of adult inpatients 2013

Frimley Park Hospital NHS Foundation Trust

Making patients' views count

National NHS patient survey programme
Survey of adult inpatients 2013

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Our purpose is to make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what we find, including performance ratings to help people choose care.

Survey of adult inpatients 2013

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

Information drawn from the survey will be used by the Care Quality Commission as part of our new Hospital Intelligent Monitoring. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The Trust Development Authority will use the results to inform the quality and governance assessment as part of their Oversight Model for NHS Trusts.

The eleventh survey of adult inpatients involved 156 acute and specialist NHS trusts. We received responses from just over 62,400 patients, which is a response rate of 49%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts were given the choice of sampling from June, July or August 2013. Trusts counted back from the last day of their chosen month, including every consecutive discharge, until they had selected 850 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2013). Fieldwork took place between September 2013 and January 2014.

Similar surveys of adult inpatients were also carried out in 2002 and from 2004 to 2012. They are part of a wider programme of NHS patient surveys, which cover a range of topics including maternity, outpatient and A&E services, ambulances, and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing '**about the same**', '**better**' or '**worse**' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S10 in the 'section scores' on page 6. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward,' 'doctors and nurses' and so forth.

This report shows the same data as published on the CQC website (www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better,' 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

Trusts have differing profiles of patients. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of patients.

To account for this, we 'standardise' the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of patients. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing. It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts in any way, for example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q41 "During your stay in hospital, did you have an operation or procedure?"

Graphs

The graphs in this report display the range of scores achieved by all trusts taking part in the survey, from the lowest score achieved (left hand side) to the highest score achieved (right hand side). The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph clearly states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same.' These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The categories described above are based on a statistic called the 'expected range' which is uniquely calculated for each trust for each question. This is the range within which we would expect a trust to score if it performed 'about the same' as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score (no green section) or the lowest possible score (no red section).

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great.

A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs and background information about the patients that responded.

Scores from last year's survey are also displayed. The column called 'change from 2012' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2012. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2012 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if your trust has merged with other trusts since the 2012 survey. Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to applicable trusts.

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?"

Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the questions' wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q51 and Q52: The information collected by Q51 "On the day you left hospital, was your discharge delayed for any reason?" and Q52 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q52 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q53: Information from Q51 and Q52 has been used to score Q53 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/Inpatientsurvey2013

The results for the adult inpatient surveys from 2002 to 2012 can be found at:
http://www.nhssurveys.org/surveys/425

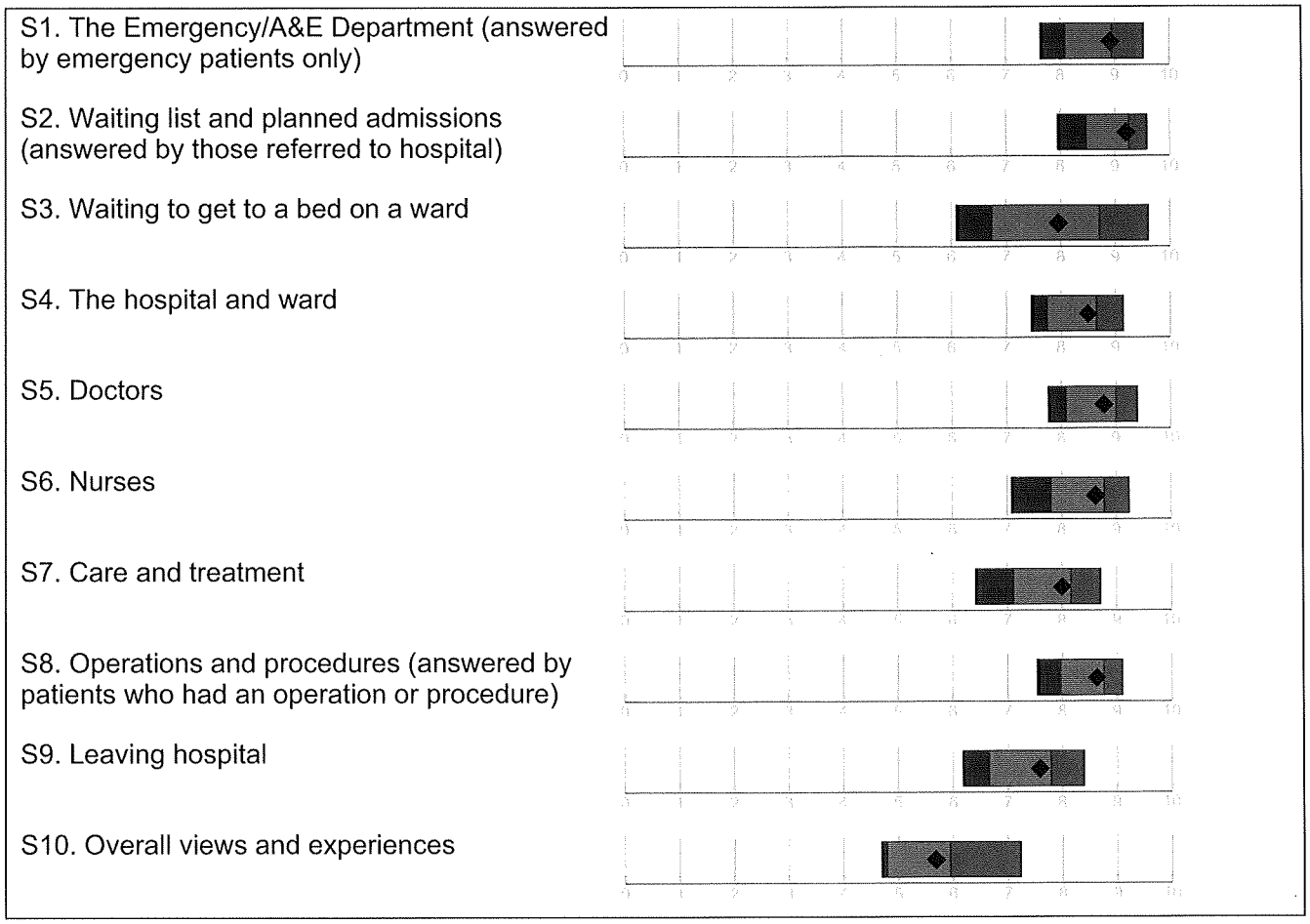
Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/705

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/public/hospital-intelligent-monitoring

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

Section scores

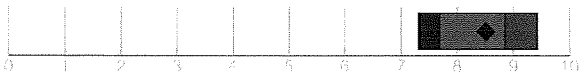


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

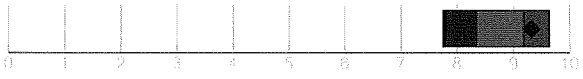
Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



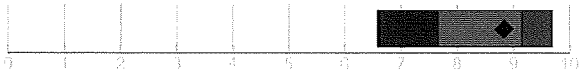
Q4. Were you given enough privacy when being examined or treated in the A&E Department?



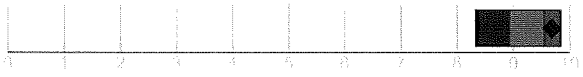
Better

Waiting list and planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

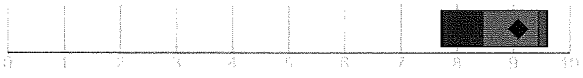


Q7. Was your admission date changed by the hospital?



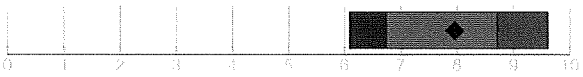
Better

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?



Waiting to get to a bed on a ward

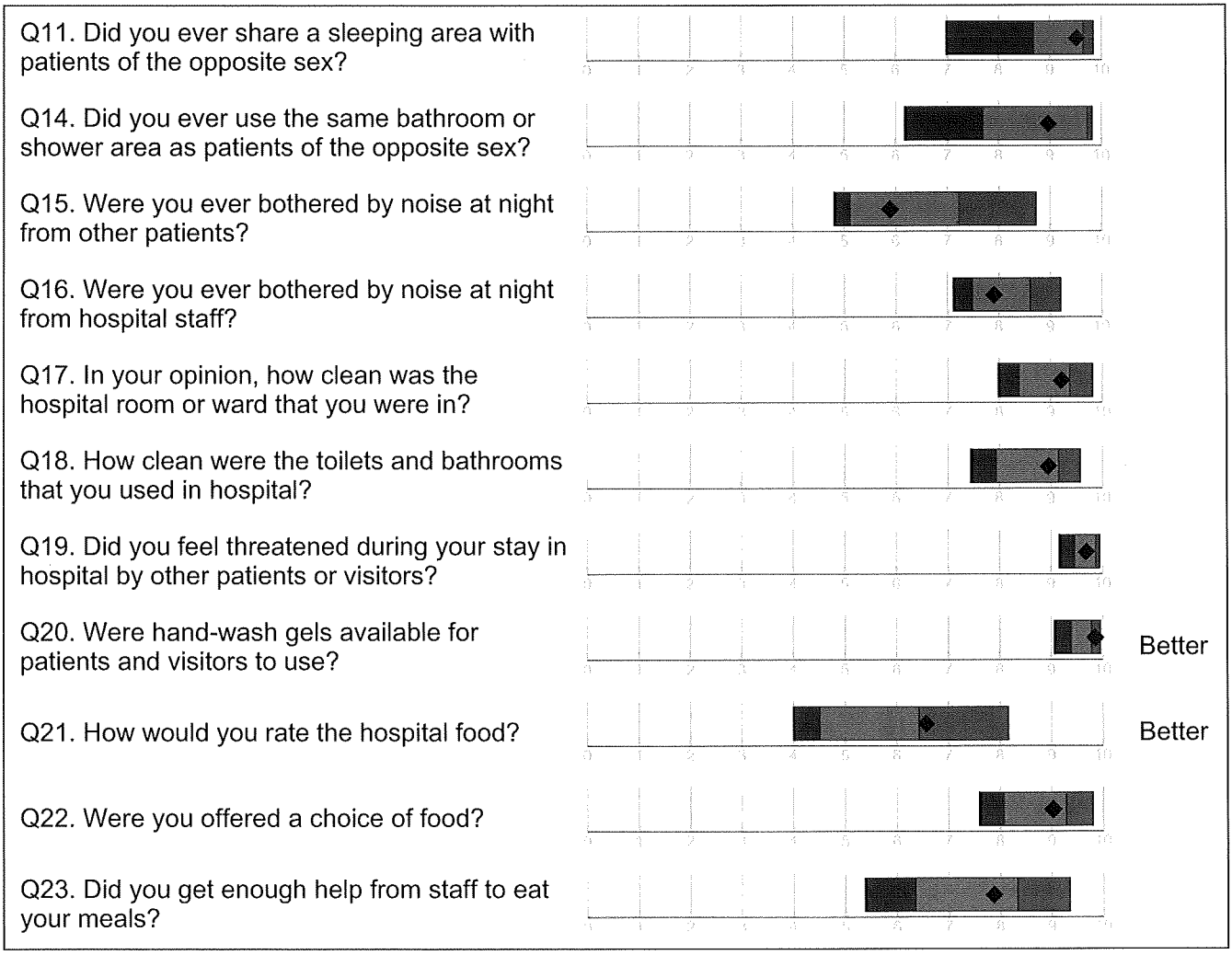
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



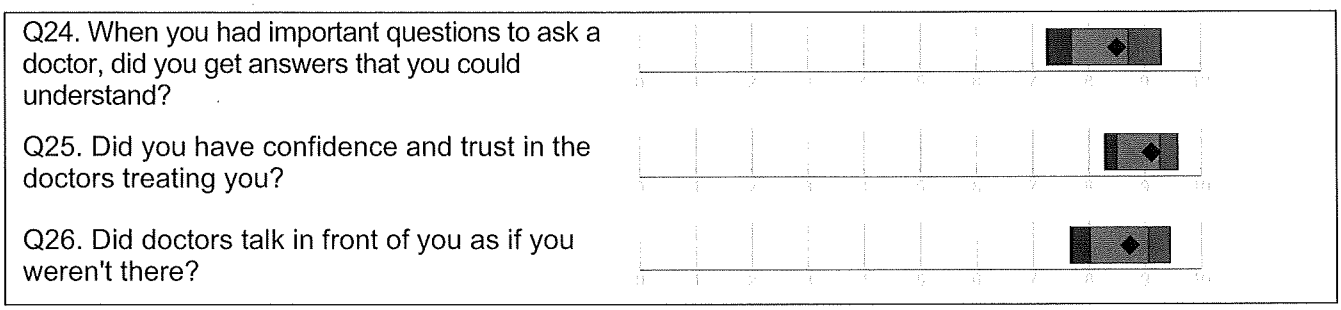
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

The hospital and ward



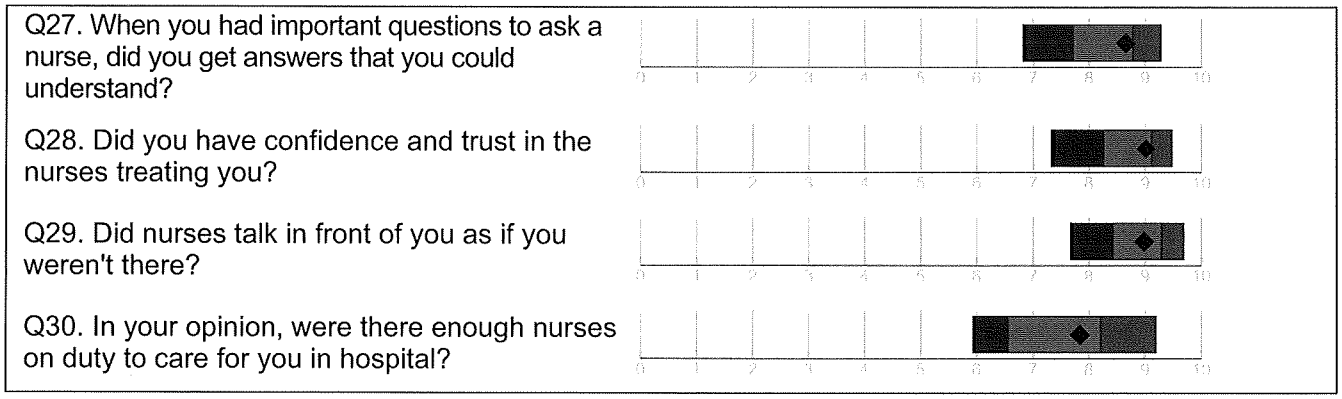
Doctors



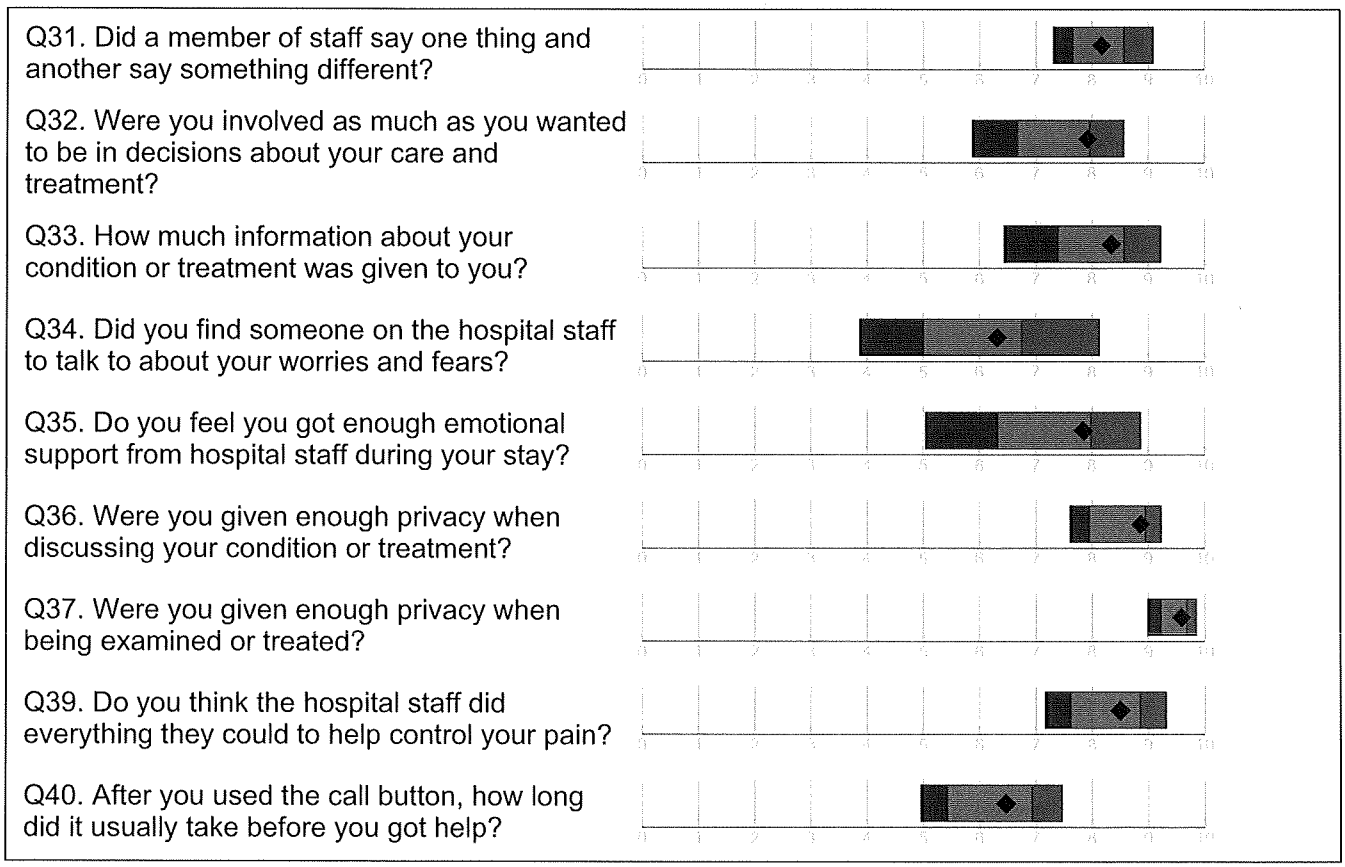
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

Nurses



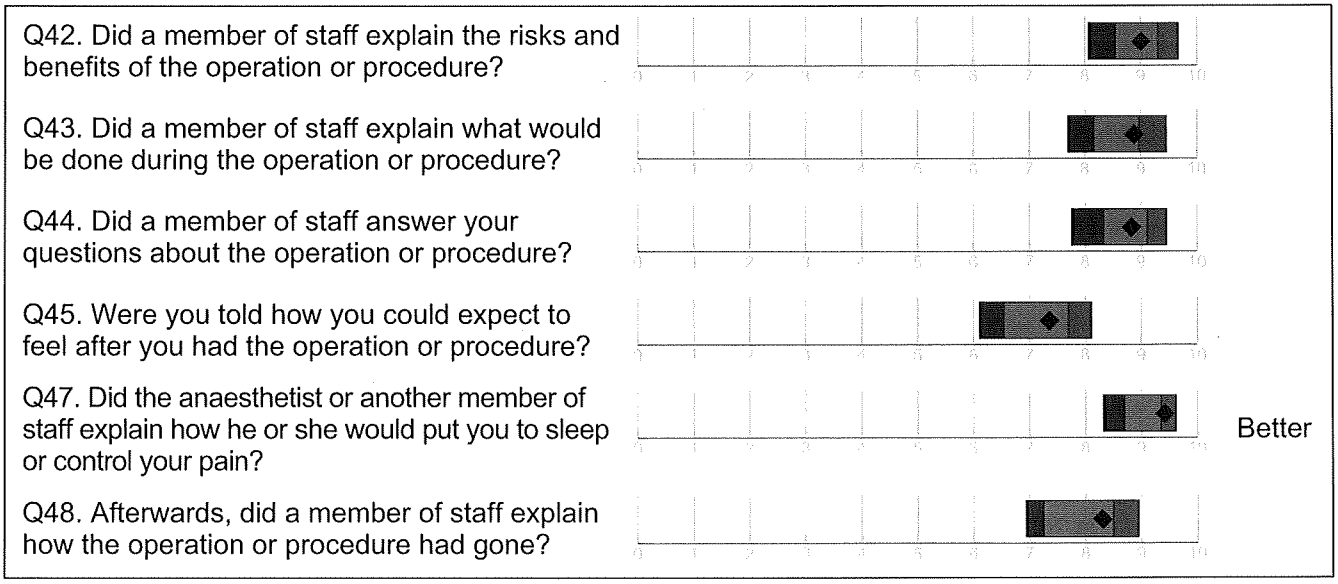
Care and treatment



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

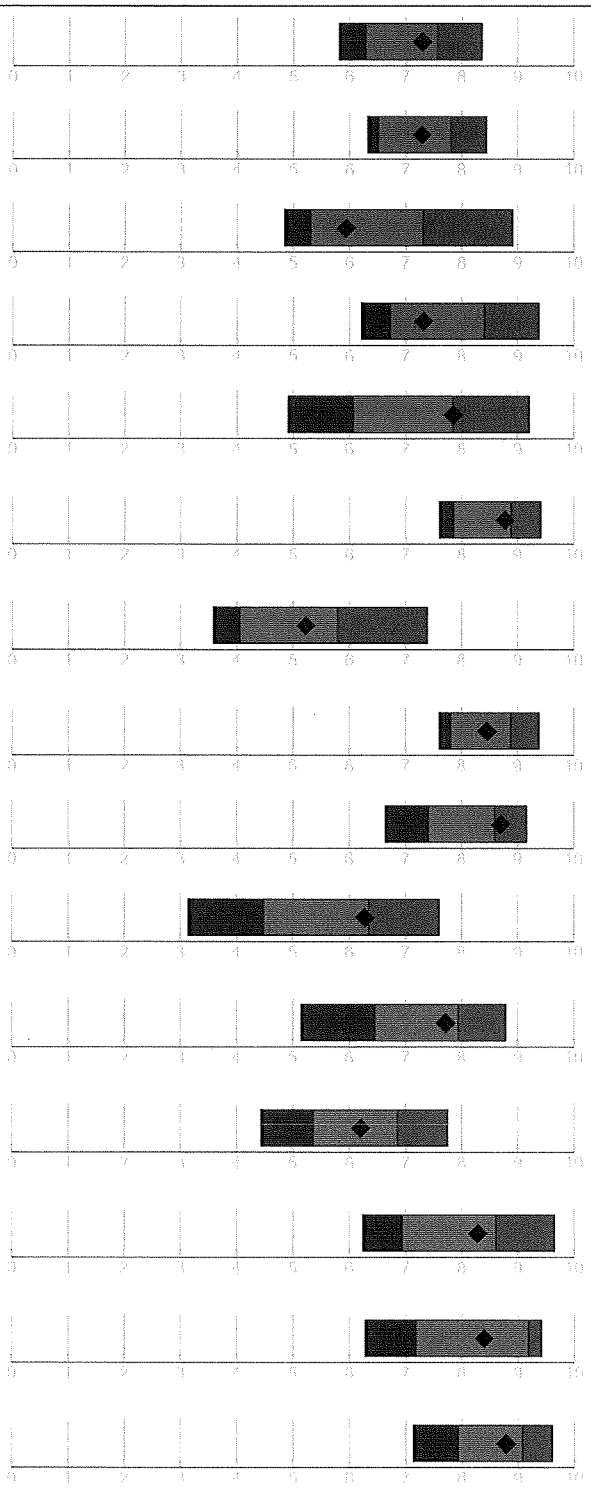
Operations and procedures (answered by patients who had an operation or procedure)



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

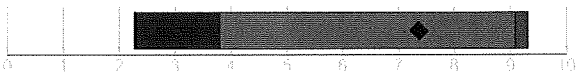
Leaving hospital



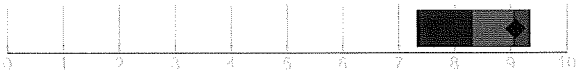
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?



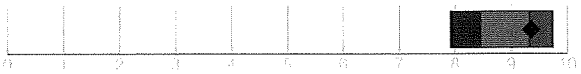
Q66. Were the letters written in a way that you could understand?



Better

Overall views and experiences

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

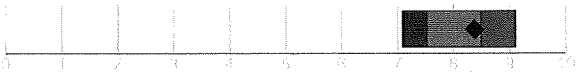


Better

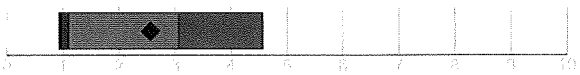
I had a very poor experience

I had a very good experience

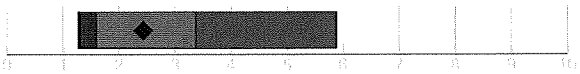
Q68. Overall...



Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?



Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.9	7.6	9.5			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.5	7.3	9.4	243	8.5	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	9.3	7.7	9.6	267	9.1	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	9.2	7.9	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.8	6.6	9.7	120	8.8	
Q7	Was your admission date changed by the hospital?	9.7	8.3	9.8	125	9.7	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.1	7.7	9.6	125		
Waiting to get to a bed on a ward							
S3	Section score	8.0	6.1	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.0	6.1	9.6	414	8.0	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The hospital and ward						
S4 Section score	8.5	7.5	9.1			
Q11 Did you ever share a sleeping area with patients of the opposite sex?	9.5	7.0	9.9	325	9.5	
Q14 Did you ever use the same bathroom or shower area as patients of the opposite sex?	9.0	6.2	9.8	369	8.3	↑
Q15 Were you ever bothered by noise at night from other patients?	5.9	4.8	8.7	413	5.7	
Q16 Were you ever bothered by noise at night from hospital staff?	7.9	7.1	9.2	415	7.9	
Q17 In your opinion, how clean was the hospital room or ward that you were in?	9.2	8.0	9.8	419	9.1	
Q18 How clean were the toilets and bathrooms that you used in hospital?	9.0	7.4	9.6	404	8.7	
Q19 Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.2	9.9	416	9.7	
Q20 Were hand-wash gels available for patients and visitors to use?	9.9	9.1	10.0	402	9.8	
Q21 How would you rate the hospital food?	6.6	4.0	8.2	402	6.0	↑
Q22 Were you offered a choice of food?	9.0	7.6	9.8	412	8.7	
Q23 Did you get enough help from staff to eat your meals?	7.9	5.4	9.4	106	7.5	
Doctors						
S5 Section score	8.8	7.8	9.4			
Q24 When you had important questions to ask a doctor, did you get answers that you could understand?	8.5	7.2	9.3	375	8.3	
Q25 Did you have confidence and trust in the doctors treating you?	9.1	8.3	9.6	416	9.0	
Q26 Did doctors talk in front of you as if you weren't there?	8.7	7.7	9.4	415	8.6	
Nurses						
S6 Section score	8.6	7.1	9.2			
Q27 When you had important questions to ask a nurse, did you get answers that you could understand?	8.7	6.8	9.3	368	8.6	
Q28 Did you have confidence and trust in the nurses treating you?	9.0	7.3	9.5	418	9.0	
Q29 Did nurses talk in front of you as if you weren't there?	9.0	7.7	9.7	415	9.0	
Q30 In your opinion, were there enough nurses on duty to care for you in hospital?	7.8	5.9	9.2	417	7.6	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Care and treatment							
S7	Section score	8.0	6.4	8.7			
Q31	Did a member of staff say one thing and another say something different?	8.2	7.3	9.1	416	8.2	
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.9	5.9	8.6	417	7.6	
Q33	How much information about your condition or treatment was given to you?	8.4	6.4	9.2	416	7.9	
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	6.3	3.9	8.1	244	5.6	↑
Q35	Do you feel you got enough emotional support from hospital staff during your stay?	7.9	5.0	8.9	255	7.0	↑
Q36	Were you given enough privacy when discussing your condition or treatment?	8.9	7.6	9.2	415	8.3	↑
Q37	Were you given enough privacy when being examined or treated?	9.6	9.0	9.8	415	9.5	
Q39	Do you think the hospital staff did everything they could to help control your pain?	8.5	7.2	9.3	253	8.6	
Q40	After you used the call button, how long did it usually take before you got help?	6.5	5.0	7.5	231	6.2	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.6	7.5	9.1			
Q42	Did a member of staff explain the risks and benefits of the operation or procedure?	9.0	8.1	9.7	234	8.8	
Q43	Did a member of staff explain what would be done during the operation or procedure?	8.9	7.7	9.5	233	8.5	
Q44	Did a member of staff answer your questions about the operation or procedure?	8.8	7.8	9.5	214	8.9	
Q45	Were you told how you could expect to feel after you had the operation or procedure?	7.4	6.1	8.1	241	6.9	
Q47	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.4	8.3	9.6	192	9.1	
Q48	Afterwards, did a member of staff explain how the operation or procedure had gone?	8.3	6.9	9.0	242	8.2	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Leaving hospital							
S9	Section score	7.6	6.2	8.4			
Q49	Did you feel you were involved in decisions about your discharge from hospital?	7.3	5.8	8.4	405	6.7	↑
Q50	Were you given enough notice about when you were going to be discharged?	7.3	6.3	8.4	415	7.2	
Q52	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	5.9	4.8	8.9	388	6.2	
Q53	How long was the delay?	7.3	6.2	9.4	387	7.5	
Q54	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	7.9	4.9	9.2	415	7.4	
Q55	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.8	7.6	9.4	338	8.4	
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	5.2	3.6	7.4	277	5.0	
Q57	Were you told how to take your medication in a way you could understand?	8.5	7.6	9.4	293	8.4	
Q58	Were you given clear written or printed information about your medicines?	8.7	6.6	9.2	327	8.0	↑
Q59	Did a member of staff tell you about any danger signals you should watch for after you went home?	6.3	3.1	7.6	322	5.4	↑
Q60	Did hospital staff take your family or home situation into account when planning your discharge?	7.7	5.1	8.8	275	7.5	
Q61	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.2	4.4	7.8	285	6.3	
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.3	6.2	9.7	392	8.5	
Q63	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.4	6.3	9.4	110	8.9	
Q64	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.8	7.1	9.6	213	8.8	
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	7.4	2.3	9.3	387	7.7	
Q66	Were the letters written in a way that you could understand?	9.1	7.3	9.3	271	8.7	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Overall views and experiences							
S10	Section score	5.7	4.7	7.2			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.4	7.9	9.7	416	9.1	
Q68	Overall...	8.4	7.1	9.1	407	8.2	
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.6	0.9	4.6	379	1.6	↑
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.4	1.3	5.9	334	2.3	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Frimley Park Hospital NHS Foundation Trust

Background information

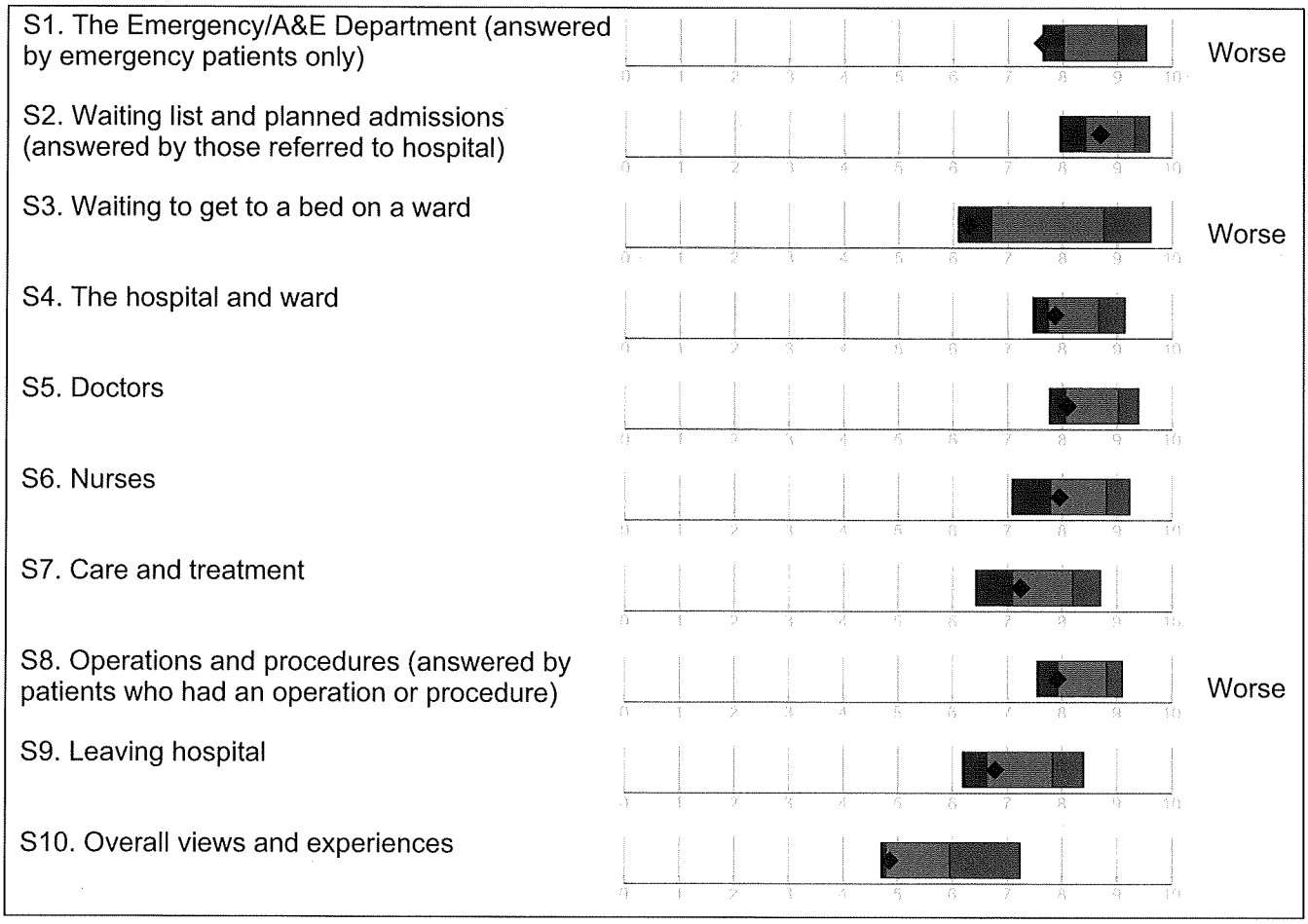
The sample	This trust	All trusts
Number of respondents	423	62443
Response Rate (percentage)	51	49

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	45	46
Female	55	54
Age group (percentage)	(%)	(%)
Aged 16-35	8	7
Aged 36-50	11	12
Aged 51-65	22	24
Aged 66 and older	59	57
Ethnic group (percentage)	(%)	(%)
White	92	89
Multiple ethnic group	0	1
Asian or Asian British	1	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	6	6
Religion (percentage)	(%)	(%)
No religion	17	16
Buddhist	0	0
Christian	77	78
Hindu	1	1
Jewish	0	1
Muslim	1	2
Sikh	0	0
Other religion	1	1
Prefer not to say	1	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	94	94
Gay/lesbian	1	1
Bisexual	1	0
Other	1	1
Prefer not to say	4	4

Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

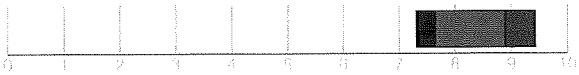
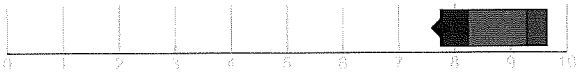
Section scores



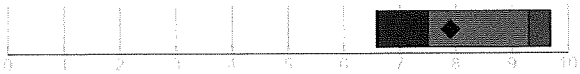
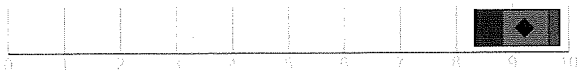
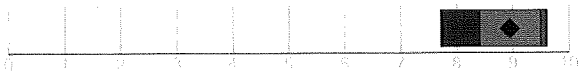
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Heatherwood and Wexham Park Hospitals NHS Foundation Trust

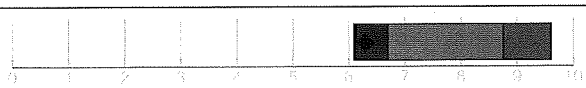
The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?		Worse
Q4. Were you given enough privacy when being examined or treated in the A&E Department?		Worse

Waiting list and planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?	
Q7. Was your admission date changed by the hospital?	
Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	

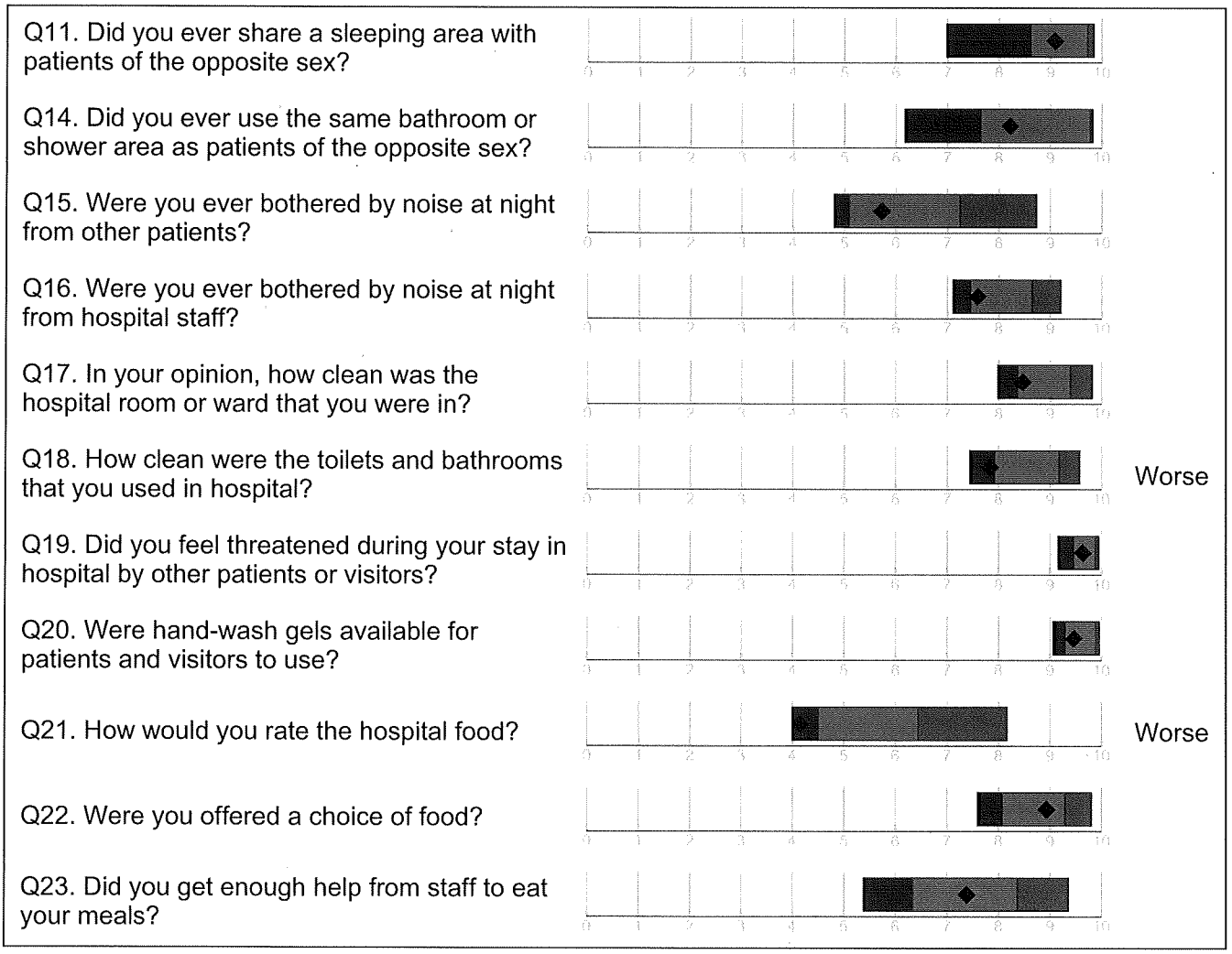
Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?		Worse

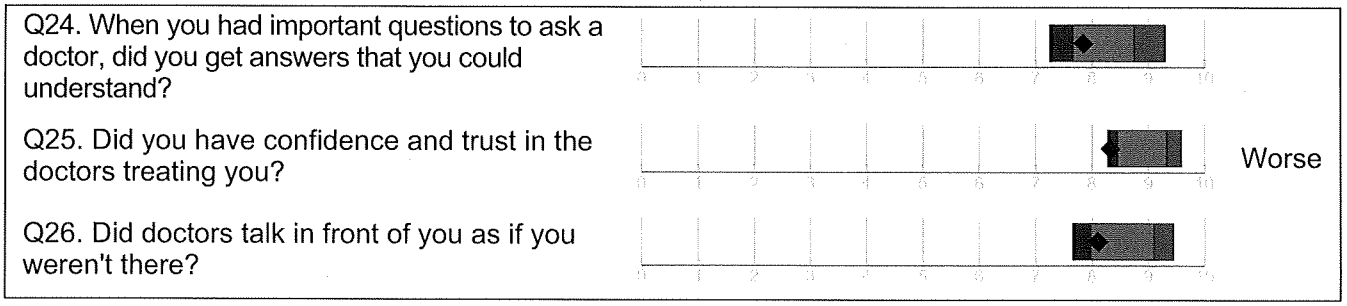
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Heatherwood and Wexham Park Hospitals NHS Foundation Trust

The hospital and ward



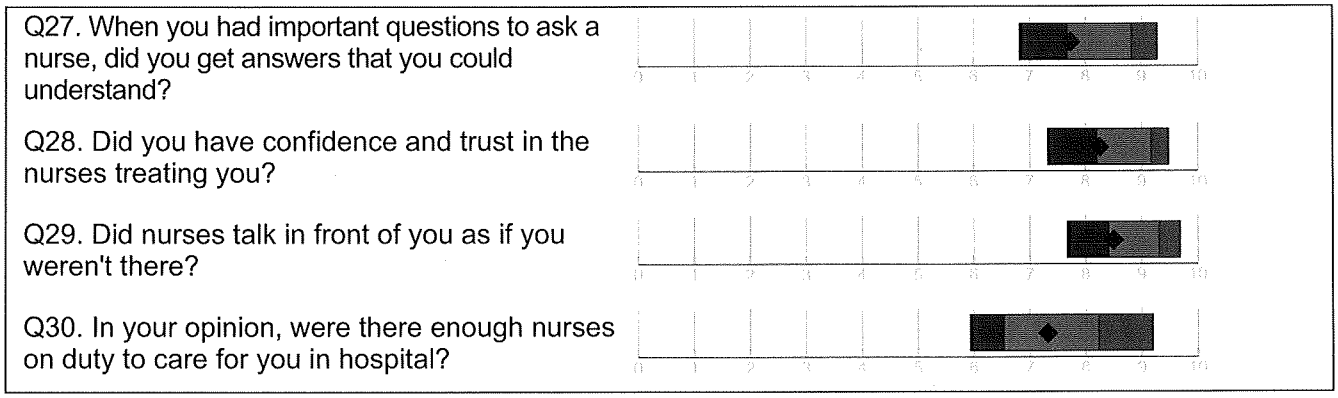
Doctors



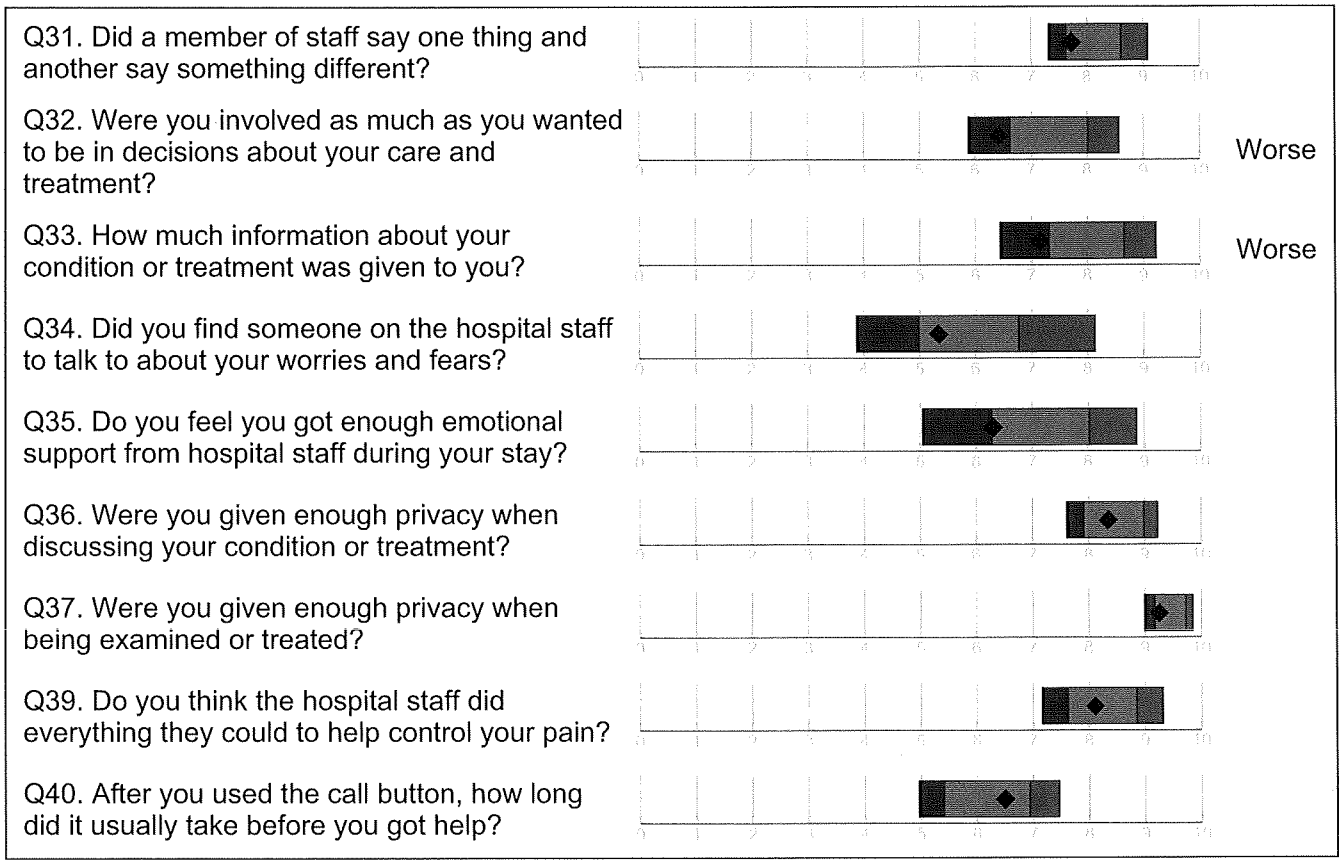
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Nurses



Care and treatment

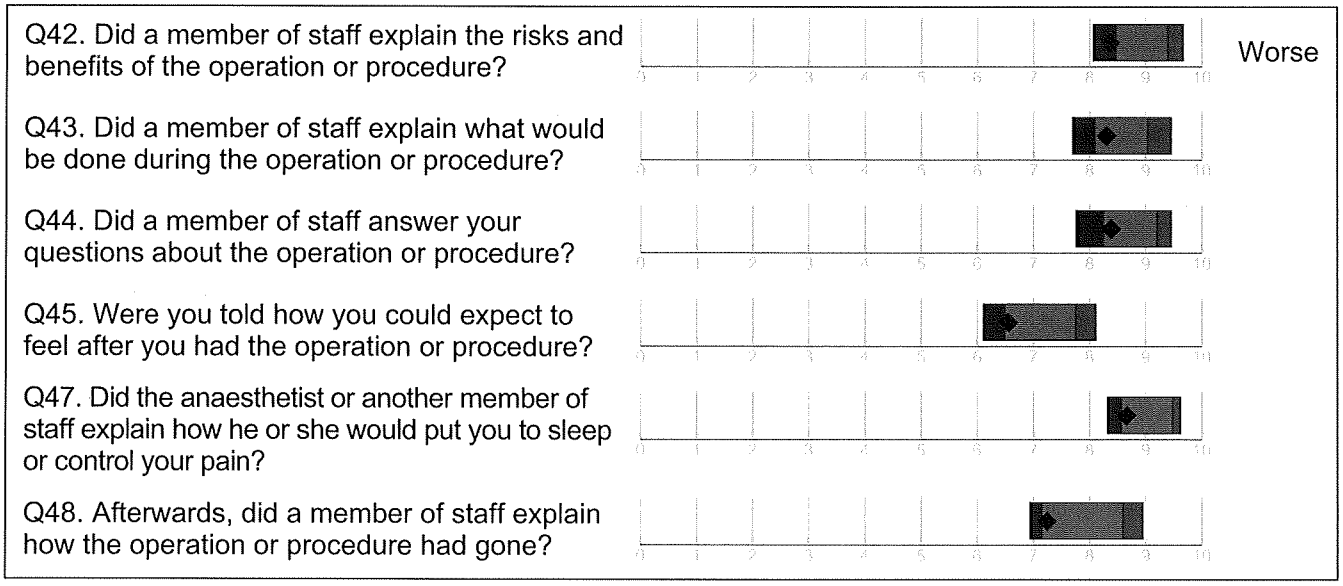


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

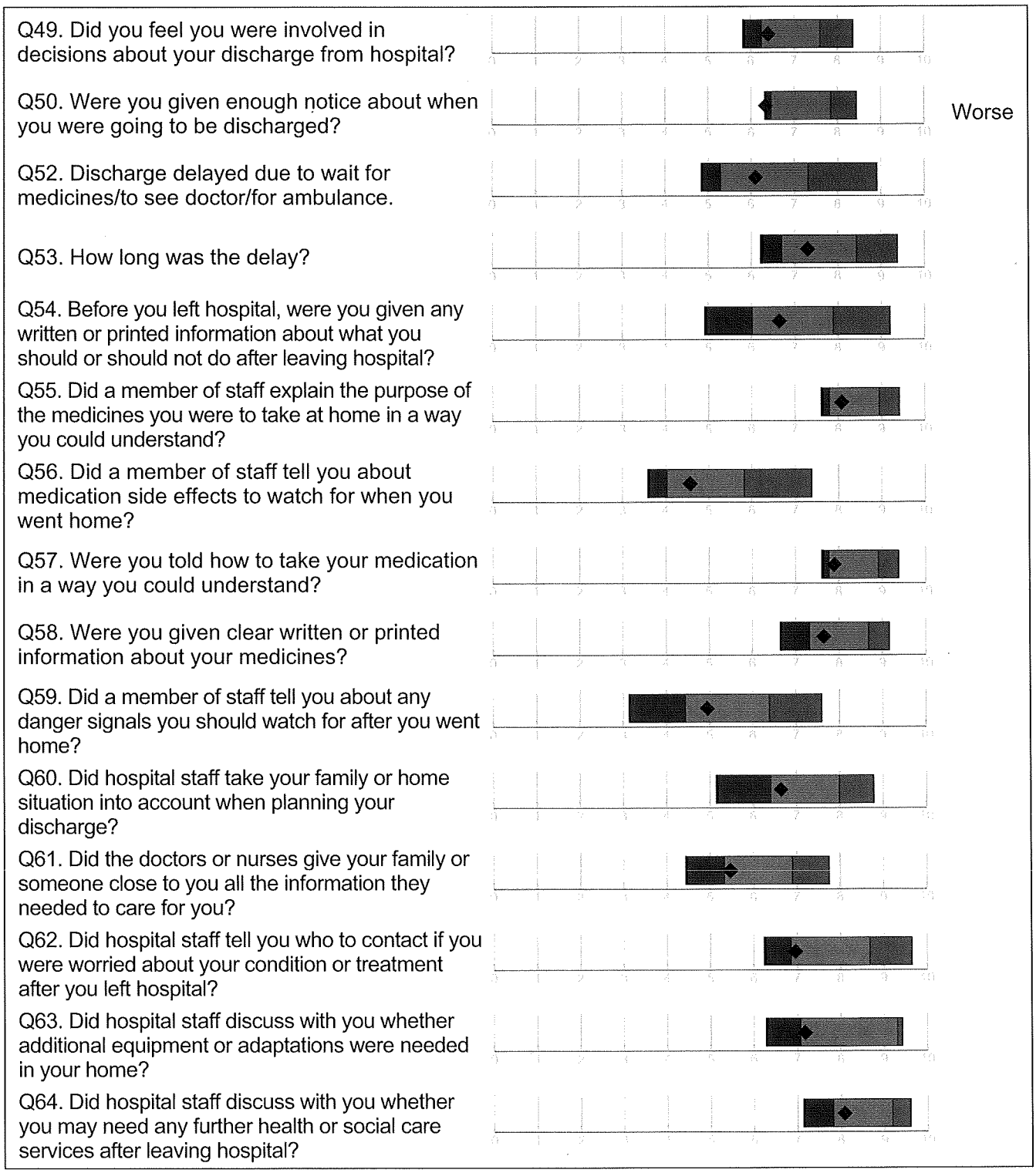
Operations and procedures (answered by patients who had an operation or procedure)



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Leaving hospital

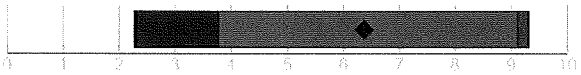


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

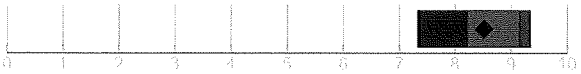
Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

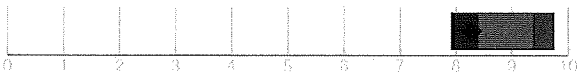


Q66. Were the letters written in a way that you could understand?



Overall views and experiences

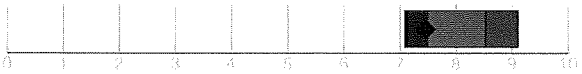
Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?



Worse

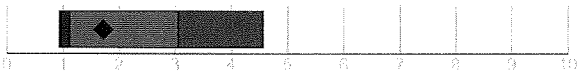
Q68. Overall...

I had a very poor experience — I had a very good experience

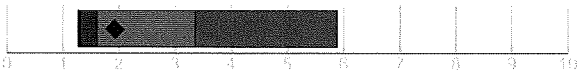


Worse

Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?



Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
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Worst performing trusts		

Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	7.6	7.6	9.5			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	7.5	7.3	9.4	227	7.7	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	7.7	7.7	9.6	236	8.0	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.7	7.9	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	7.9	6.6	9.7	100	7.4	
Q7	Was your admission date changed by the hospital?	9.2	8.3	9.8	102	8.9	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.9	7.7	9.6	98		
Waiting to get to a bed on a ward							
S3	Section score	6.3	6.1	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	6.3	6.1	9.6	357	7.1	↓

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The hospital and ward							
S4	Section score	7.9	7.5	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.1	7.0	9.9	264	8.8	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.2	6.2	9.8	308	7.9	
Q15	Were you ever bothered by noise at night from other patients?	5.7	4.8	8.7	354	5.5	
Q16	Were you ever bothered by noise at night from hospital staff?	7.6	7.1	9.2	356	7.4	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	8.5	8.0	9.8	357	8.2	
Q18	How clean were the toilets and bathrooms that you used in hospital?	7.8	7.4	9.6	341	7.6	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.6	9.2	9.9	359	9.7	
Q20	Were hand-wash gels available for patients and visitors to use?	9.5	9.1	10.0	350	9.3	
Q21	How would you rate the hospital food?	4.2	4.0	8.2	344	3.8	
Q22	Were you offered a choice of food?	8.9	7.6	9.8	352	8.9	
Q23	Did you get enough help from staff to eat your meals?	7.4	5.4	9.4	118	6.5	
Doctors							
S5	Section score	8.1	7.8	9.4			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	7.9	7.2	9.3	325	7.7	
Q25	Did you have confidence and trust in the doctors treating you?	8.3	8.3	9.6	354	8.4	
Q26	Did doctors talk in front of you as if you weren't there?	8.1	7.7	9.4	354	8.1	
Nurses							
S6	Section score	8.0	7.1	9.2			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	7.7	6.8	9.3	327	7.5	
Q28	Did you have confidence and trust in the nurses treating you?	8.3	7.3	9.5	357	8.3	
Q29	Did nurses talk in front of you as if you weren't there?	8.5	7.7	9.7	355	8.2	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	7.3	5.9	9.2	357	7.4	

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Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Care and treatment							
S7	Section score	7.2	6.4	8.7			
Q31	Did a member of staff say one thing and another say something different?	7.7	7.3	9.1	357	7.8	
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	6.4	5.9	8.6	354	6.7	
Q33	How much information about your condition or treatment was given to you?	7.2	6.4	9.2	358	7.3	
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	5.3	3.9	8.1	238	4.4	↑
Q35	Do you feel you got enough emotional support from hospital staff during your stay?	6.3	5.0	8.9	231	6.5	
Q36	Were you given enough privacy when discussing your condition or treatment?	8.4	7.6	9.2	356	8.0	
Q37	Were you given enough privacy when being examined or treated?	9.3	9.0	9.8	360	9.2	
Q39	Do you think the hospital staff did everything they could to help control your pain?	8.1	7.2	9.3	241	7.8	
Q40	After you used the call button, how long did it usually take before you got help?	6.5	5.0	7.5	195	6.2	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	7.9	7.5	9.1			
Q42	Did a member of staff explain the risks and benefits of the operation or procedure?	8.4	8.1	9.7	200	8.5	
Q43	Did a member of staff explain what would be done during the operation or procedure?	8.3	7.7	9.5	207	8.4	
Q44	Did a member of staff answer your questions about the operation or procedure?	8.4	7.8	9.5	185	9.0	↓
Q45	Were you told how you could expect to feel after you had the operation or procedure?	6.6	6.1	8.1	209	6.3	
Q47	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.7	8.3	9.6	177	8.7	
Q48	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.2	6.9	9.0	206	7.2	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Leaving hospital							
S9	Section score	6.8	6.2	8.4			
Q49	Did you feel you were involved in decisions about your discharge from hospital?	6.4	5.8	8.4	340	6.2	
Q50	Were you given enough notice about when you were going to be discharged?	6.3	6.3	8.4	352	6.5	
Q52	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.1	4.8	8.9	326	5.6	
Q53	How long was the delay?	7.3	6.2	9.4	323	6.9	
Q54	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	6.6	4.9	9.2	352	6.1	
Q55	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.1	7.6	9.4	275	7.8	
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	4.6	3.6	7.4	248	3.9	
Q57	Were you told how to take your medication in a way you could understand?	7.9	7.6	9.4	253	7.4	
Q58	Were you given clear written or printed information about your medicines?	7.7	6.6	9.2	260	7.6	
Q59	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.0	3.1	7.6	281	4.1	↑
Q60	Did hospital staff take your family or home situation into account when planning your discharge?	6.6	5.1	8.8	240	5.7	↑
Q61	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.5	4.4	7.8	254	5.1	
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.0	6.2	9.7	326	6.6	
Q63	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	7.2	6.3	9.4	107	6.2	
Q64	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.1	7.1	9.6	182	7.3	
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	6.4	2.3	9.3	301	5.7	
Q66	Were the letters written in a way that you could understand?	8.5	7.3	9.3	186	8.2	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Overall views and experiences							
S10	Section score	4.9	4.7	7.2			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.3	7.9	9.7	357	8.4	
Q68	Overall...	7.5	7.1	9.1	339	7.2	
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7	0.9	4.6	332	0.9	↑
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.9	1.3	5.9	296	1.6	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Background information

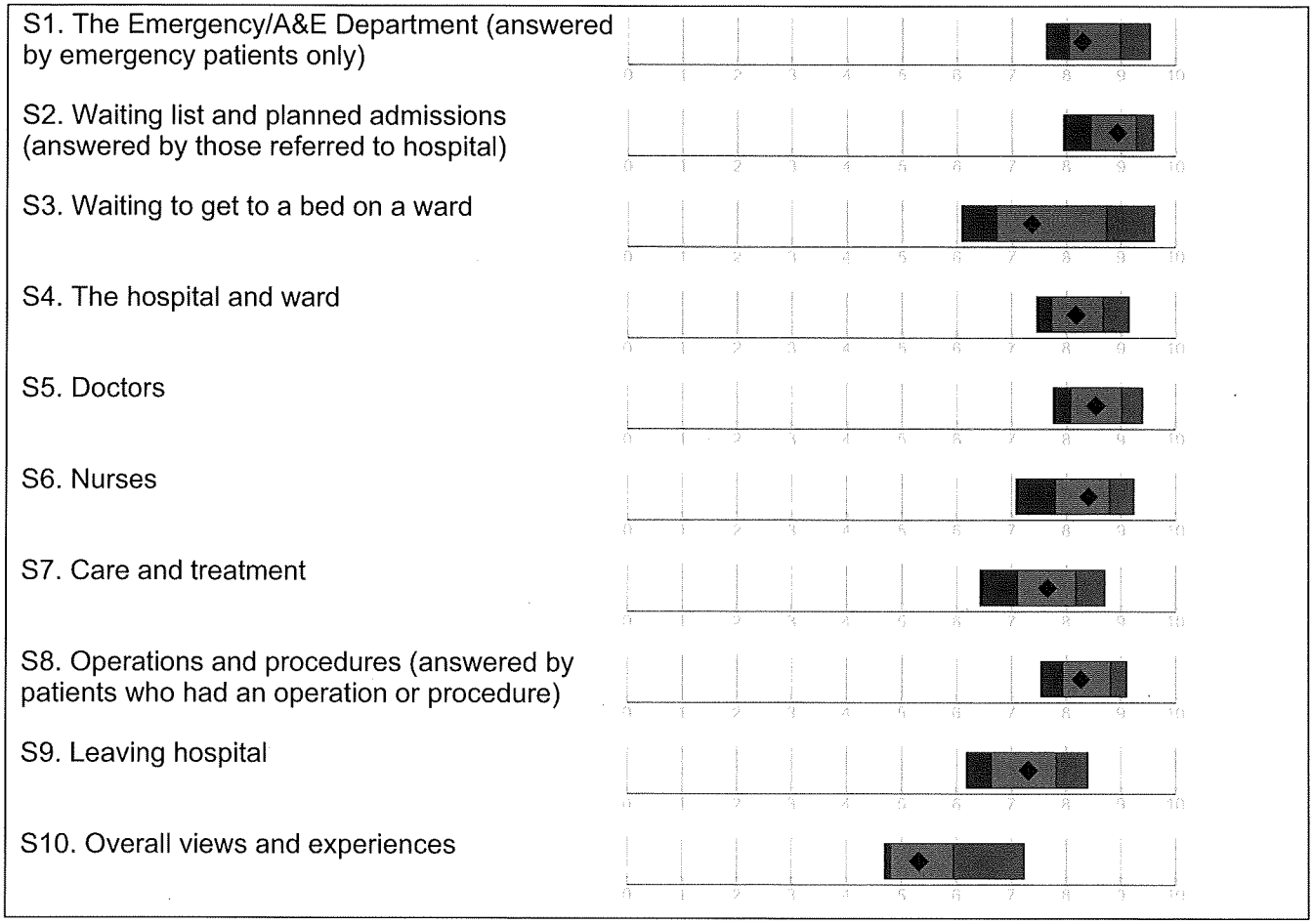
The sample	This trust	All trusts
Number of respondents	366	62443
Response Rate (percentage)	45	49

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	47	46
Female	53	54
Age group (percentage)	(%)	(%)
Aged 16-35	8	7
Aged 36-50	10	12
Aged 51-65	25	24
Aged 66 and older	57	57
Ethnic group (percentage)	(%)	(%)
White	83	89
Multiple ethnic group	2	1
Asian or Asian British	9	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	5	6
Religion (percentage)	(%)	(%)
No religion	13	16
Buddhist	1	0
Christian	72	78
Hindu	3	1
Jewish	0	1
Muslim	4	2
Sikh	5	0
Other religion	1	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	92	94
Gay/lesbian	1	1
Bisexual	1	0
Other	1	1
Prefer not to say	6	4

Survey of adult inpatients 2013

Royal Berkshire NHS Foundation Trust

Section scores

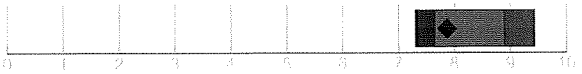


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

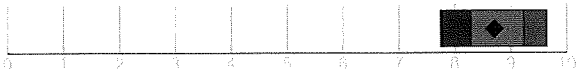
Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

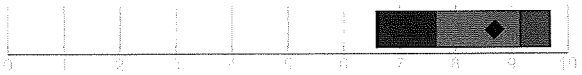


Q4. Were you given enough privacy when being examined or treated in the A&E Department?

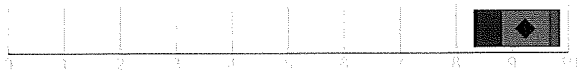


Waiting list and planned admissions (answered by those referred to hospital)

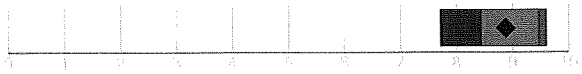
Q6. How do you feel about the length of time you were on the waiting list?



Q7. Was your admission date changed by the hospital?

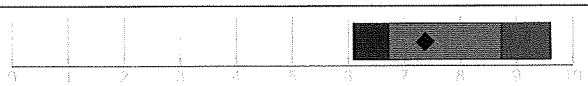


Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?



Waiting to get to a bed on a ward

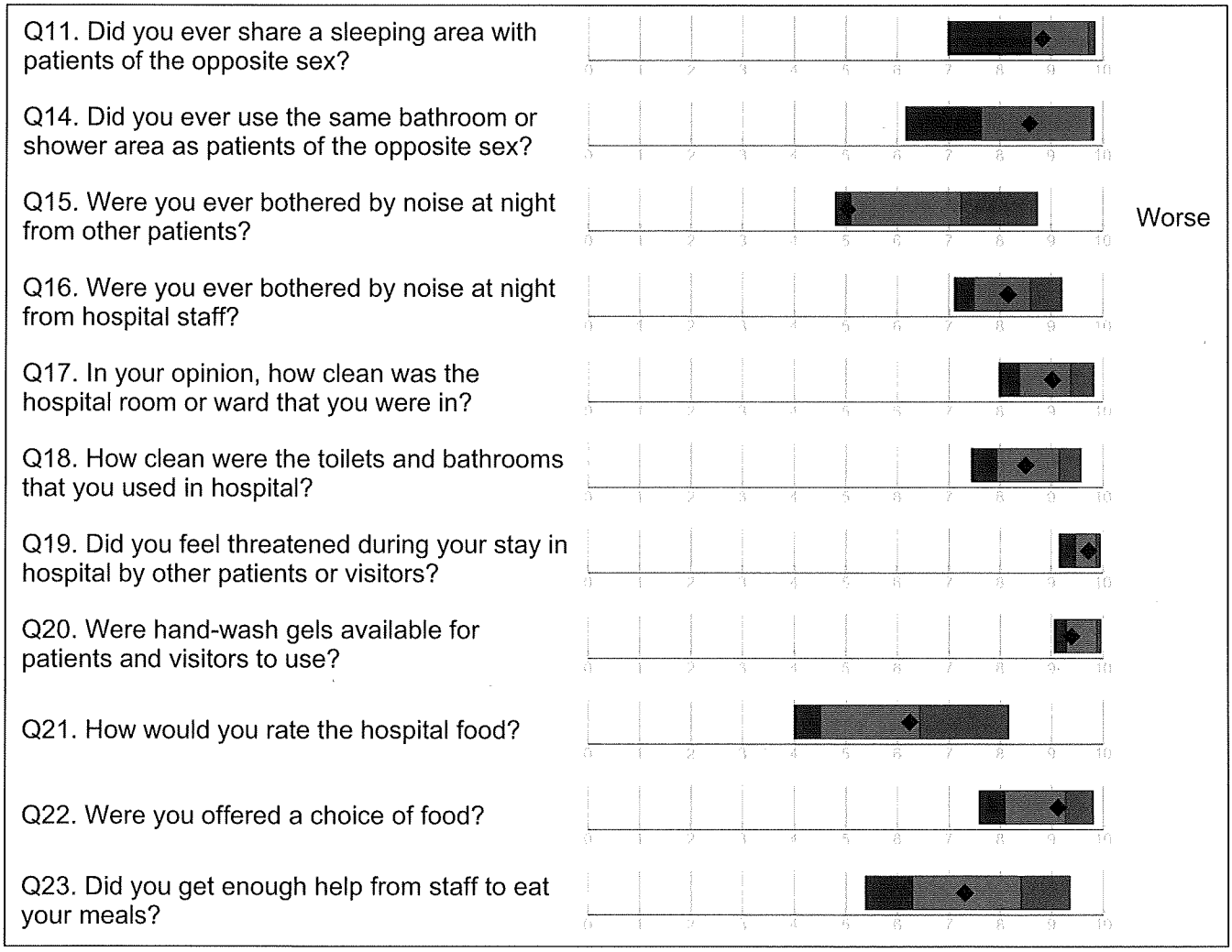
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



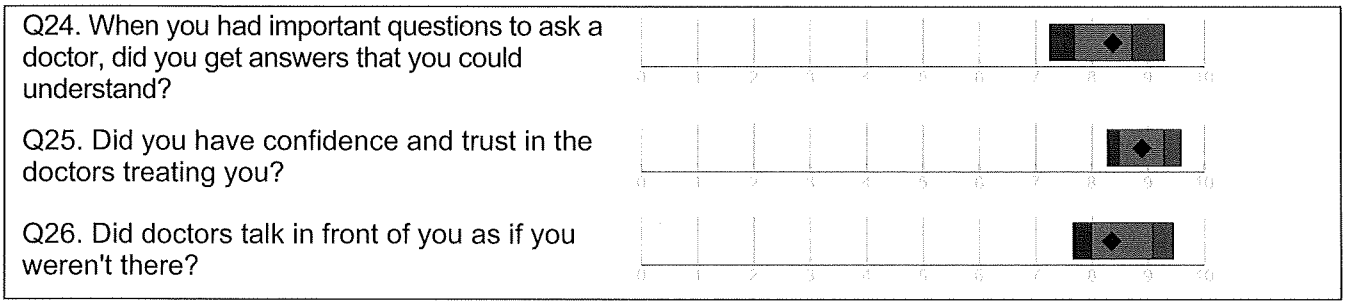
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

The hospital and ward



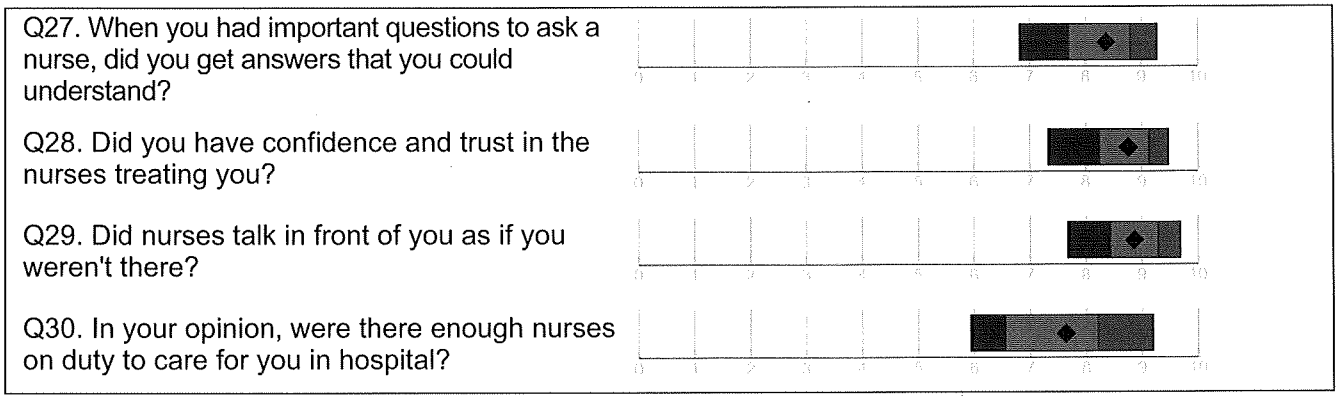
Doctors



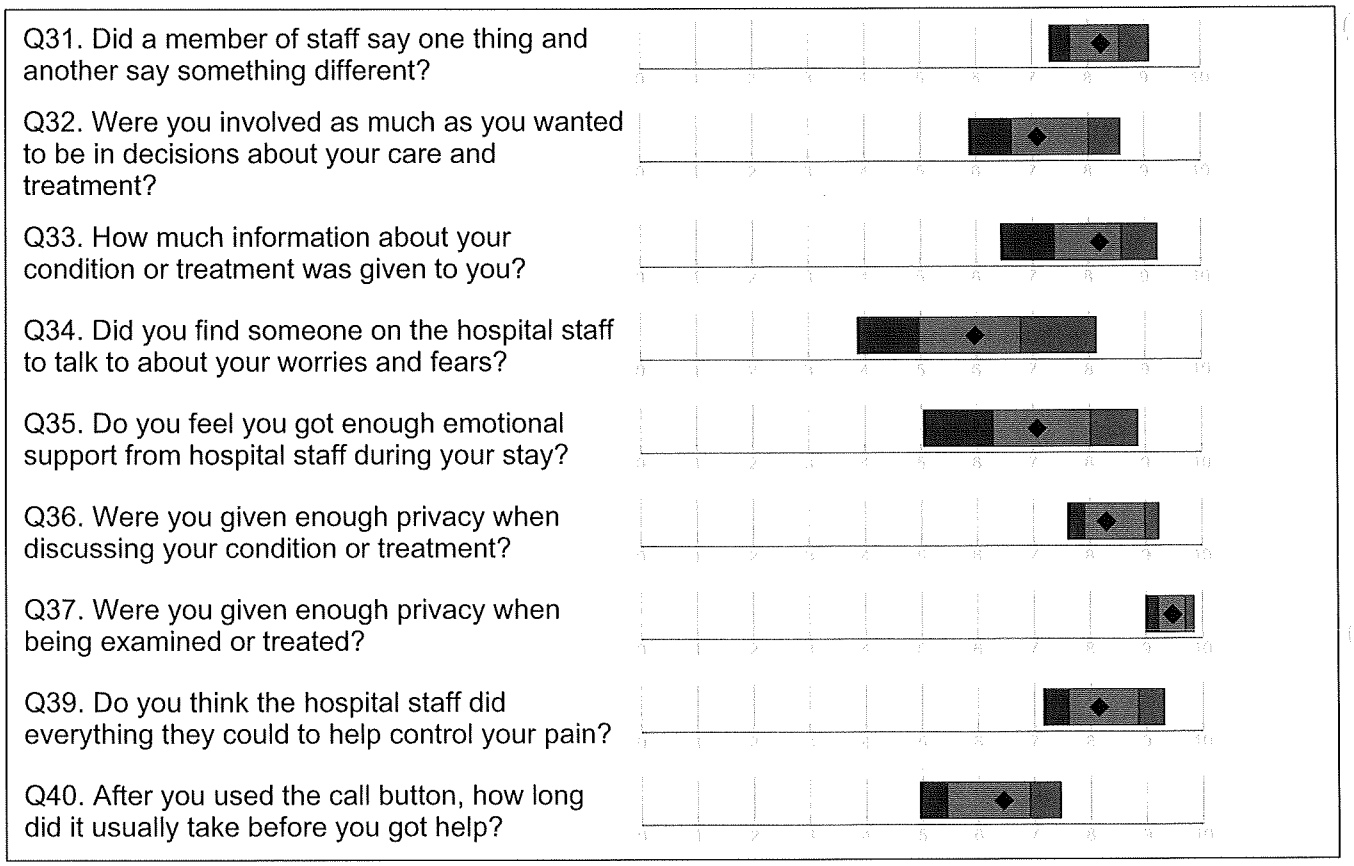
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

Nurses



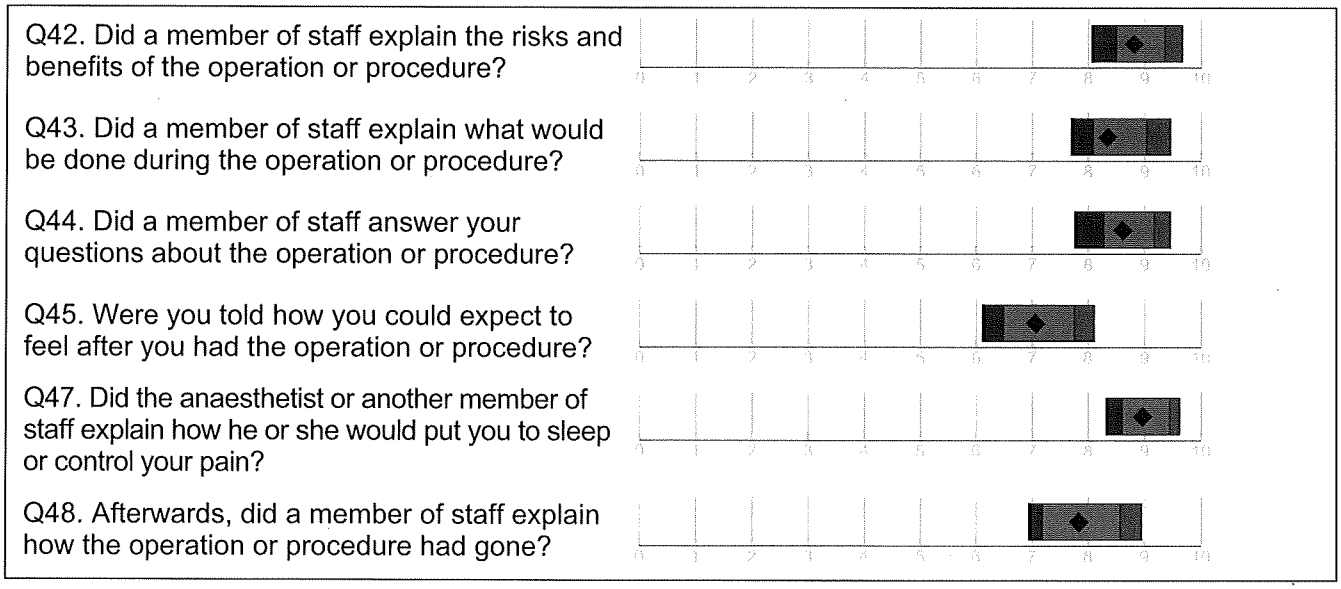
Care and treatment



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

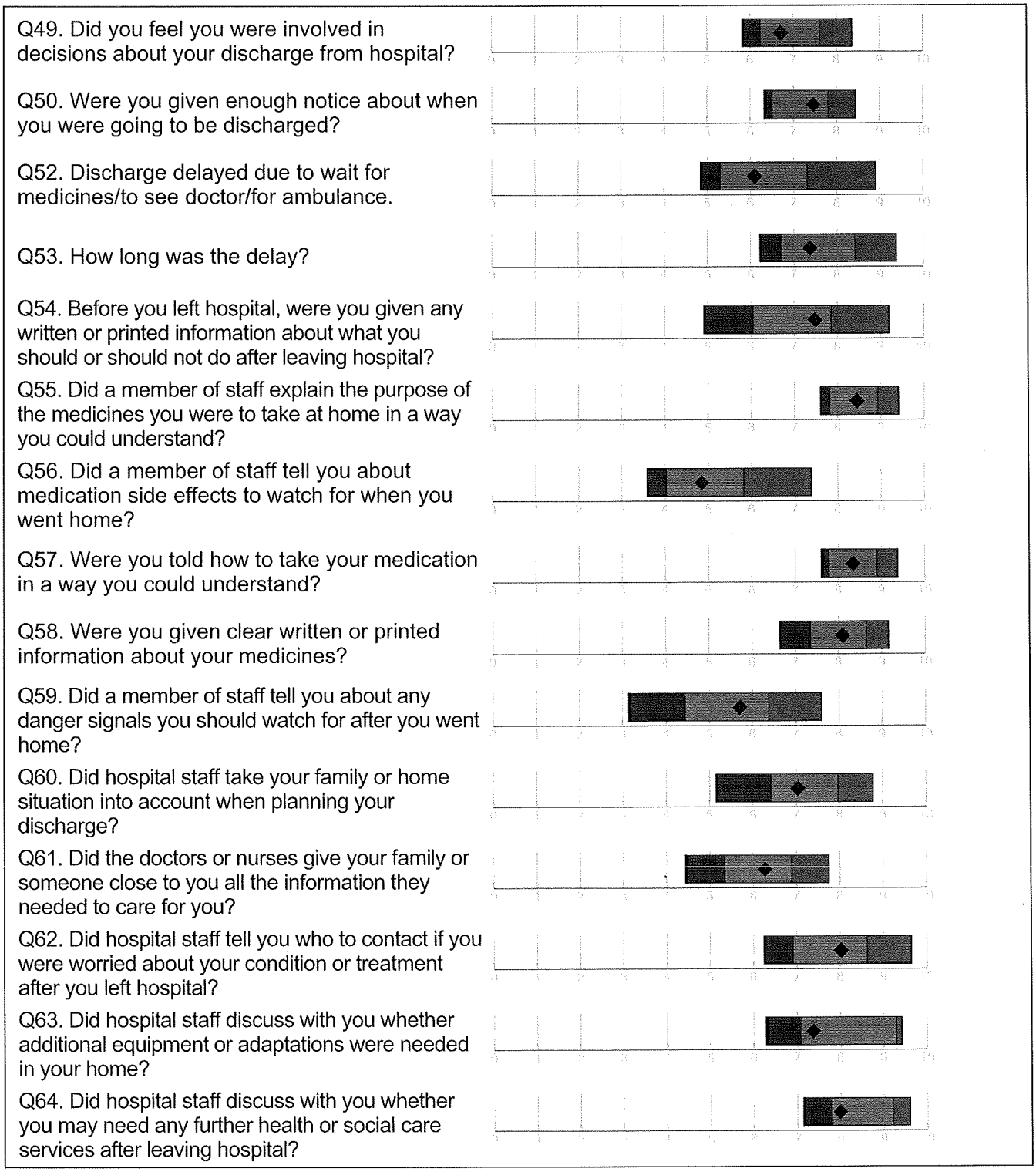
Operations and procedures (answered by patients who had an operation or procedure)



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

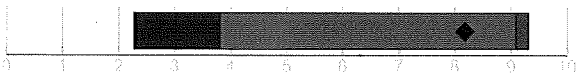
Leaving hospital



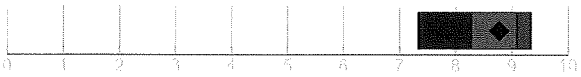
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

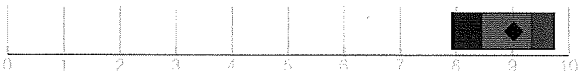


Q66. Were the letters written in a way that you could understand?

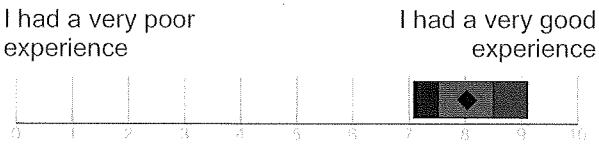


Overall views and experiences

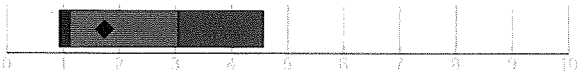
Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?



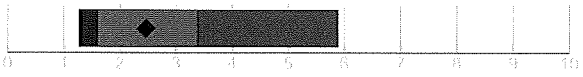
Q68. Overall...



Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?



Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.3	7.6	9.5			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	7.9	7.3	9.4	221	8.2	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.7	7.7	9.6	243	8.5	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.9	7.9	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.7	6.6	9.7	130	8.4	
Q7	Was your admission date changed by the hospital?	9.2	8.3	9.8	132	9.4	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.9	7.7	9.6	132		
Waiting to get to a bed on a ward							
S3	Section score	7.4	6.1	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.4	6.1	9.6	383	7.3	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The hospital and ward							
S4	Section score	8.2	7.5	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	8.8	7.0	9.9	305	9.2	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.6	6.2	9.8	331	8.6	
Q15	Were you ever bothered by noise at night from other patients?	5.0	4.8	8.7	386	5.3	
Q16	Were you ever bothered by noise at night from hospital staff?	8.2	7.1	9.2	388	8.0	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.0	8.0	9.8	389	8.9	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.5	7.4	9.6	372	8.4	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.2	9.9	391	9.8	
Q20	Were hand-wash gels available for patients and visitors to use?	9.4	9.1	10.0	381	9.6	
Q21	How would you rate the hospital food?	6.2	4.0	8.2	374	6.1	
Q22	Were you offered a choice of food?	9.1	7.6	9.8	390	8.9	
Q23	Did you get enough help from staff to eat your meals?	7.3	5.4	9.4	99	7.2	
Doctors							
S5	Section score	8.5	7.8	9.4			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	8.4	7.2	9.3	339	8.4	
Q25	Did you have confidence and trust in the doctors treating you?	8.9	8.3	9.6	389	8.8	
Q26	Did doctors talk in front of you as if you weren't there?	8.4	7.7	9.4	388	8.3	
Nurses							
S6	Section score	8.4	7.1	9.2			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	6.8	9.3	338	8.5	
Q28	Did you have confidence and trust in the nurses treating you?	8.8	7.3	9.5	389	8.9	
Q29	Did nurses talk in front of you as if you weren't there?	8.9	7.7	9.7	382	9.1	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	7.6	5.9	9.2	387	7.8	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Care and treatment							
S7	Section score	7.7	6.4	8.7			
Q31	Did a member of staff say one thing and another say something different?	8.2	7.3	9.1	385	8.0	
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.1	5.9	8.6	386	7.3	
Q33	How much information about your condition or treatment was given to you?	8.2	6.4	9.2	391	7.9	
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	6.0	3.9	8.1	208	6.2	
Q35	Do you feel you got enough emotional support from hospital staff during your stay?	7.1	5.0	8.9	225	7.3	
Q36	Were you given enough privacy when discussing your condition or treatment?	8.3	7.6	9.2	384	8.4	
Q37	Were you given enough privacy when being examined or treated?	9.5	9.0	9.8	389	9.4	
Q39	Do you think the hospital staff did everything they could to help control your pain?	8.2	7.2	9.3	236	8.1	
Q40	After you used the call button, how long did it usually take before you got help?	6.5	5.0	7.5	230	6.1	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.3	7.5	9.1			
Q42	Did a member of staff explain the risks and benefits of the operation or procedure?	8.8	8.1	9.7	208	9.1	
Q43	Did a member of staff explain what would be done during the operation or procedure?	8.3	7.7	9.5	205	8.8	
Q44	Did a member of staff answer your questions about the operation or procedure?	8.6	7.8	9.5	179	8.9	
Q45	Were you told how you could expect to feel after you had the operation or procedure?	7.1	6.1	8.1	212	7.2	
Q47	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.0	8.3	9.6	188	9.2	
Q48	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.8	6.9	9.0	206	7.7	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Leaving hospital							
S9	Section score	7.3	6.2	8.4			
Q49	Did you feel you were involved in decisions about your discharge from hospital?	6.7	5.8	8.4	373	7.1	
Q50	Were you given enough notice about when you were going to be discharged?	7.5	6.3	8.4	387	7.6	
Q52	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.1	4.8	8.9	360	5.5	
Q53	How long was the delay?	7.4	6.2	9.4	355	6.8	↑
Q54	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	7.5	4.9	9.2	379	7.6	
Q55	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.5	7.6	9.4	274	8.7	
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	4.9	3.6	7.4	247	5.1	
Q57	Were you told how to take your medication in a way you could understand?	8.3	7.6	9.4	252	8.6	
Q58	Were you given clear written or printed information about your medicines?	8.1	6.6	9.2	260	8.3	
Q59	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.7	3.1	7.6	286	5.7	
Q60	Did hospital staff take your family or home situation into account when planning your discharge?	7.0	5.1	8.8	252	7.1	
Q61	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.3	4.4	7.8	265	6.5	
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.0	6.2	9.7	348	8.1	
Q63	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	7.4	6.3	9.4	104	8.1	
Q64	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.0	7.1	9.6	191	8.6	
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	8.2	2.3	9.3	356	7.4	↑
Q66	Were the letters written in a way that you could understand?	8.8	7.3	9.3	288	8.9	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Overall views and experiences							
S10	Section score	5.3	4.7	7.2			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.0	7.9	9.7	390	8.9	
Q68	Overall...	8.0	7.1	9.1	369	7.8	
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7	0.9	4.6	343	1.2	↑
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.5	1.3	5.9	309	2.3	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Royal Berkshire NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	396	62443
Response Rate (percentage)	47	49

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	46	46
Female	54	54
Age group (percentage)	(%)	(%)
Aged 16-35	9	7
Aged 36-50	11	12
Aged 51-65	22	24
Aged 66 and older	58	57
Ethnic group (percentage)	(%)	(%)
White	92	89
Multiple ethnic group	1	1
Asian or Asian British	3	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	4	6
Religion (percentage)	(%)	(%)
No religion	20	16
Buddhist	1	0
Christian	74	78
Hindu	0	1
Jewish	1	1
Muslim	1	2
Sikh	1	0
Other religion	1	1
Prefer not to say	1	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	93	94
Gay/lesbian	0	1
Bisexual	0	0
Other	1	1
Prefer not to say	5	4

HEALTH OVERVIEW AND SCRUTINY PANEL
3 JULY 2014

PROTOCOL BETWEEN THE HEALTH & WELLBEING BOARD, HEALTHWATCH BRACKNELL FOREST AND THE HEALTH OVERVIEW AND SCRUTINY PANEL

Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 To ask the Health Overview and Scrutiny Panel to adopt the Protocol between the Health & Wellbeing Board, Healthwatch Bracknell Forest (HWBF) and the Panel.

2 RECOMMENDATIONS

2.1 That the Health Overview and Scrutiny Panel adopts the Protocol between the Health & Wellbeing Board, Healthwatch Bracknell Forest and the Panel, as recommended by the Health and Wellbeing Board, for signature by the Chairman.

3 REASONS FOR RECOMMENDATIONS

3.1 The Health & Wellbeing Board and HWBF have already agreed the protocol, which reflects national guidance, also reflecting the earlier protocol entered into between the Panel and HWBF.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

5.1 The minute of the Health and Wellbeing Board meeting on 10 April 2014 concerning the protocol is attached.

5.2 The minute of the Panel meeting on 3 October 2013, attached, records the Panel agreeing a protocol with Healthwatch Bracknell Forest. The new protocol subsumes the wording of the October 2013 protocol.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS / EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / CONSULTATION

6.1 Not applicable.

Contact for further information

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e-mail: richard.beaumont@bracknell-forest.gov.uk

Minutes of 10 April 2014 Health & Wellbeing Board meeting

Protocol Between the Health & Wellbeing Board, Healthwatch and the Health O&S Panel

The report before the Board set out a draft protocol between the Board, Healthwatch and the Health Overview & Scrutiny Panel. It was agreed that whilst at times there may be some overlap between the work of Healthwatch and the Health Overview & Scrutiny Panel, they would work together to ensure there was no duplication. It was noted that it would be important to review this working arrangement over time.
It was RESOLVED that;
i) the protocol between the Health & Wellbeing Board, Healthwatch and Health Overview and Scrutiny be agreed
ii) the Board recommended that the protocol be presented to the Health Overview and Scrutiny Panel for agreement.

Minutes of Health Overview and Scrutiny Panel Thursday, 3 October 2013

Local Healthwatch

It was **AGREED** that the Panel: endorsed the following draft protocol regarding O&S joint working with Healthwatch Bracknell Forest:

> *Healthwatch Bracknell Forest (HWBF) and Bracknell Forest Council's Overview and Scrutiny (O&S) are committed to the establishment of a mutually supportive and beneficial relationship through partnership working. The Council's Health O&S Panel (HO&SP) will take the lead on this relationship, referring matters to other O&S Panels as appropriate.*
>
> *HWBF will provide evidence based feedback, attend HO&SP meetings as an observer, relevant workshops and working groups.*
>
> *O&S may refer issues to HWBF for investigation or may commission HWBF to research evidence.*
>
> *HWBF may refer matters to O&S for the purposes of securing information and expertise.*
>
> *In accordance with The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (SI 2021:3094), HWBF will escalate issues as necessary to the HO&SP. The respective O&S Panel has an obligation to acknowledge HWBF referrals within 20 working days of receipt.*

Protocol between the Bracknell Forest Health and Wellbeing Board, the Bracknell Forest Council Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest.

This protocol concerns the relationship between the Bracknell Forest Health and Wellbeing Board, Bracknell Forest Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest. Its purpose is to ensure that:

- Mechanisms are put in place for exchanging information and work programmes so that issues of mutual concern/interest are recognised at an early stage and are dealt with in a spirit of co-operation and in a way that ensures the individual responsibilities of the Health and Wellbeing Board, the Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest are managed

- There is a shared understanding of the process of referrals and exchange of information and that arrangements are in place for dealing with these.

……
Chairman of the Health and Wellbeing Board

……..
Chairman of the Health Overview and Scrutiny Panel

…….
Chair of the Healthwatch Bracknell Forest Board

THE BRACKNELL FOREST HEALTH AND WELLBEING BOARD

The Health and Wellbeing Board is a committee of the Council. The membership of the Board includes local Councillors, officers of the Council, representatives from the NHS and local Healthwatch. The board takes the lead on improving health and wellbeing outcomes and reducing health inequalities for the local community. Although there is a prescribed minimum membership, boards operate differently responding to local circumstances. Health and Wellbeing Boards are an executive function of the Council and are responsible for identifying current and future health and social care needs and assets through the Joint Strategic Needs Assessment and developing Joint Health and Wellbeing Strategies to set health and social care priorities.

The role of the Health and Wellbeing Board is to:

- Set priorities and to drive the development of health and social care within the Borough
- Bring together individual and organisational knowledge, expertise and experience and to act as a system leader
- Develop a strategic, area-wide view of health and social care needs and resources through the Joint Strategic Needs Assessment
- Agree an area-wide alignment of services to deliver improved health and wellbeing through the Joint Health and Wellbeing Strategy
- Facilitate shared understanding of information to improve outcomes from decision making
- Develop arrangements to involve key providers in improved health and social care.

To do this the Board will:

- Communicate and engage with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their health and wellbeing by working with other stakeholders
- Have oversight of the relevant health and social care resources across all sectors so that it can drive the further integration of health, social care and public health
- Monitor performance against agreed targets and service standards across the local health and social care economy to inform future commissioning by the Council and the National Health Service.

HEALTH OVERVIEW AND SCRUTINY PANEL

Councils with social care functions can hold NHS bodies to account for the quality of their services through powers to obtain information, ask questions in public, and make recommendations for improvements that have to be considered. Proposals for major changes to health services can be referred to the Secretary of State for determination if they are not considered to be in the interests of local health services. Within Bracknell Forest this is done in conjunction with the Executive Member and Council. The way Councils use the powers is commonly known as "health scrutiny" and forms part of Councils' overview and scrutiny arrangements. From April 2013, all commissioners and providers of publicly funded health and social care services may be subject to overview and scrutiny, as may the health and social care priorities arising from the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. Scrutiny also has a pro-active role in helping to understand communities and tackle health inequalities.

The Health Overview & Scrutiny Panel has decided that the overall aim of Health scrutiny is:

> *'Through constructive challenge and accountability, to work with the Executive, the Health and Wellbeing Board and Health Service Providers to help ensure good health services are provided to residents of Bracknell Forest, reducing health inequalities, and helping everyone to stay fit and lead healthy lives.'*

In relation to the Health and Wellbeing Board and Healthwatch, the role of the Health Overview and Scrutiny Panel is to:

- Evaluate policies arising from processes and decisions and outcomes from services
- Consider whether service changes are in the best interests of the local health service
- Carry out pro-active qualitative reviews that can inform and enhance policy and services
- Work with Healthwatch to capture the views of people using services to inform their work.

To do this the Health Overview and Scrutiny Panel will:

- Take the lead for Overview and Scrutiny function on the relationship between O&S with Healthwatch Bracknell Forest, referring matters to other panels as appropriate
- Refer issues to Healthwatch Bracknell Forest for investigation or may commission HWBF to research evidence.

HEALTHWATCH BRACKNELL FOREST

Local Healthwatch is the consumer champion for health and social care, representing the collective voice of people who use services and the public in general. Healthwatch will build up a local picture of community needs, aspirations and assets, and the experience of people. It will report any concerns about services to commissioners, providers and Scrutiny committees. It does so by engaging with local communities including networks of local voluntary organisations, people who have used or are using services, and the public. Through its seat on the Health and Wellbeing Board, local Healthwatch will present information for the Joint Strategic Needs Assessment and discuss and agree with other members of the Board a Joint Health and Wellbeing Strategy. It will also present information to Healthwatch England to help form a national picture of health and social care. Local Authorities have the responsibility to ensure that the local Healthwatch operates effective and is value for money; managing this through local contractual arrangements.

The role of Healthwatch Bracknell Forest is to:

- Act as a “watchdog” and advocate for consumers
- Be a source of information for people in the community; to share information from networks of voluntary and community groups
- Gather and present evidence and information for Joint Strategic Needs Assessments and support scrutiny reviews
- Use good public engagement to demonstrate the “real-time” experiences of people who have experience of using health and social care services
- Highlight concerns about services to health scrutiny. In line with national guidance, Healthwatch has a duty to report concerns to Health Scrutiny. Within Bracknell Forest, it has been agreed that Health Overview and Scrutiny Panel will act as the recipient of the concerns.
- Cascade information to people in the community and the public about services and support that is available.

To do this Healthwatch Bracknell Forest will:

- Collect and share relevant public opinion and experiences using an evidence based approach
- Have an oversight of trends and local issues
- Access the Healthwatch England repository of information
- Exercise its powers to “Enter and View”
- Hold regular discussions with people in the community, commissioners and providers
- Provide evidence based feedback, attend Health Overview and Scrutiny Panel meetings as an observer, relevant workshops and working groups.
- Pefer matters to the Health Overview and Scrutiny Panel for the purposes of securing information and expertise
- In accordance with The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health And Local Healthwatch) Regulations 2012 (SI 2012:3094), escalate issues as necessary to the Health

Overview and Scrunity Panel. The respective Overview and Scrunity Panel has an obligation to acknowledge referrals within 20 working days of receipt.

For more information about Healthwatch Bracknell Forest please visit: www.healthwatchbracknellforest.co.uk

WORKING PRINCIPLES

Given that the common aims of the Health and Wellbeing Board, the Health Overview and Scrutiny Panel and Healthwatch Bracknell Forest are to improve outcomes for people and ensure the commissioning and delivery of high quality, appropriate and efficient services, it is vital that they:

- Work in a climate of mutual respect, courtesy and transparency
- Have a shared understanding of their respective roles, responsibilities, priorities and different perspectives
- Promote and foster open relationships where issues of common interest are shared and challenged in a constructive and mutually supportive manner
- Share work programmes and information or data that have obtained to avoid duplication of effort

PRACTICE EXAMPLES

Scenario 1: The refreshed JSNA has indicated a need for integrated health and social care teams aligned with GP practices

Health and Wellbeing Board	The board has a duty to support integrated services and, reflecting on the JSNA, **decides** to include integrated teams as a priority in the Joint Health and Wellbeing Strategy. Following the implementation of the strategy, it **assesses what impact** the changes have had and **makes recommendations** for improvement.
Local Healthwatch	**Undertakes local research** about what people who use services are looking for, **identifies gaps** on service provision and **feeds the outcomes** onto the Health and Wellbeing Board to i**nfluence** the Joint Health and Wellbeing Strategy.
Health Scrutiny	**Examines** the process in light of members' knowledge of the local area and **makes recommendations** about how people in the community, particularly vulnerable groups, can be informed about changes to services. Depending on the outcomes or any issues raised, scrutiny could consider whether it would merit the establishment of a working group, recognising that there may be competing priorities.

Scenario 2: An issue related to health inequalities: A low uptake of child vaccination in particular wards

Health and Wellbeing Board	The refreshed JSNA indicates a low uptake that has implications for health and social care in some Council wards. Because the reasons are unclear, the Health and Wellbeing Board **asks Health Scrutiny to review** the issue.
Local Healthwatch	Through their seat one the Health and Wellbeing Board, local Healthwatch were **involved in reviewing** the JSNA, and now it uses its local networks to **gather views** about why some children are not being immunised and **reports** this to the Health and Wellbeing Board and Scrutiny.
Health Scrutiny	**Scrutiny asks Local Healthwatch** to gather local views. As a result of the discussions with Clinical Commissioning Groups, schools, health visitors and social workers, **makes recommendations** about ways to improve immunisations.

Scenario 3: A reconfiguration of maternity services across Council areas

Health and Wellbeing Board	Providers have proposed this as a solution to improving outcomes and make better use of available resources. The health and wellbeing board **assesses** whether the plans fit their Joint Health and Wellbeing Strategy and **takes a strategic view** on the outcomes and engagement with the clinical commissioning groups.
Local Healthwatch	**Undertakes a comprehensive exercise to gather views** from people who use services and the public, **checks** whether consultations reflect what is known about best practice and **presents views** as a health and wellbeing board member and to Council scrutiny during the formal consultation process.
Health Scrutiny	Agrees that proposals are a substantial/significant variation and, either individually or through joint arrangements with other Councils, **engages in early discussions** with the commissioners/providers regarding policy, plans and consultations. During the formal consultation stage it would **analyse the proposals** in a public forum, taking evidence and **coming to a conclusion** about whether the proposals are in the best interest of the local health service. This would be in conjunction with key officers and the Executive Member to seek to secure a "Council" response to proposals.

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
3 JULY 2014

OVERVIEW AND SCRUTINY PROGRESS REPORT
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report highlights Overview and Scrutiny (O&S) activity during the period December 2013 to May 2014.

2 RECOMMENDATION

2.1 To note Overview and Scrutiny activity and developments over the period December 2013 to May 2014, set out in section 5 to 6, and Appendices 1 and 2.

3 REASONS FOR RECOMMENDATIONS

3.1 The Chief Executive has asked for a six monthly report to be produced on O&S activity.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Overview and Scrutiny Structure and Membership

5.1 Council appointed Mrs Linda Wellsteed, Secondary School Parent Governor Representative, to the O&S Commission, and the Commission appointed Mrs Wellsteed and Ms Catherine Barrett (Children's social care representative) to the Children, Young People & Learning Overview and Scrutiny Panel. The Commission also appointed Cllr Mrs Phillips to the Adult Social Care and Housing Panel and Dr David Norman as a co-optee to the Health O&S Panel. All new members were provided with induction training on O&S. There are vacancies for a substitute councillor vacancy on the Commission and one of the Panels. Action continues to be taken periodically on the long-running vacancy for a representative of the Catholic Diocese. The O&S Panels will elect Chairmen and appoint Vice Chairmen at their next meetings.

Overview and Scrutiny Work Programme and Working Groups

5.2 The programme for 2013-14 was completed broadly as planned, the only notable exception being the Health O&S Panel deciding not to embark upon a planned review. A routine report has been submitted to each O&S Commission meeting, monitoring progress against the O&S Work Programme, using traffic light indicators. The work programme for 2014-15 was approved as part of the Annual Report of O&S for 2013-14, over which there was formal consultation with the Corporate Management Team and the Executive.

5.3 The table at Appendix 1 sets out the current status of the O&S Working Groups, along with the list of completed reviews.

Overview and Scrutiny Commission

5.4 The O&S Commission met on 30 January, 17 and 20 March, 1 and 14 May (Annual meeting). The main items included:

- The Council's draft budget proposals for 2014/15.
- The recommendations to the O&S Commission from the Health O&S Panel's working group on the Francis report.
- The annual report of Overview and Scrutiny for 2013/14, together with items to be included in the Commission's Work Programme for 2014/15.
- Receiving an update on the work of the Economic and Skills Development Partnership.
- Reviewing the quarterly performance reports for the Corporate Services Department, the Chief Executive's Office and the Council as a whole.
- Meeting representatives of Thames Valley Police and the Community Safety Partnership to review their performance and the refreshed Community Safety Plan.
- The Call-In of the Executive Member for Planning and Transport's decision concerning the introduction of a no right turn restriction in Binfield. The Commission decided to refer this to Council, which resolved to recommend to the Executive Member that he reconsider his decision. The Executive Member subsequently decided to discontinue the process for the making of the Traffic Regulation Order, and that the proposal for a Traffic Regulation Order would be considered further when additional traffic data is available.

5.5 At each of its meetings, the Commission also reviewed corporate items on the Executive Forward Plan, and monitored the delivery of the O&S work programme, with particular reference to the Commission's own Working Groups.

5.6 The first meeting of the Commission's Working Group on Business Rates was held on 19 May. The O&S Commission's next meeting is on 10 July 2014, when the main item is likely to be a meeting with the Director of Security at Broadmoor Hospital.

Environment, Culture and Communities O&S Panel

5.7 Meetings of the Panel were held on 21 January and 18 March, 2014. During the meetings the Panel considered and commented on:

- Quarterly Service Reports for the relevant quarters.
- The Council's draft budget proposals 2014/15.
- Schools Annual Environmental Management Report 2012/13.
- Neighbourhood Planning Update Briefing.
- Bracknell Forest Borough Local Plan Update.
- Recycling Reward Scheme Update.
- Sustainable Modes of Transport.
- Integrated Transport Capital Programme 2013/14.
- 2013/14 Highway Maintenance Programme.
- O&S Work Programme 2014/15.
- Six monthly O&S progress report.
- Scheduled Executive key and non-key decisions.

5.8 Following the completion of work undertaken by a working group of the Panel which guided the Borough's emerging Bus Strategy for implementation in April 2014, the Panel established a new working group to review the Council's cultural services offering, in the

context of pressure on public finance, with particular reference to libraries and assistance for South Hill Park (see Appendix 1).

5.9 Actions arising from Panel meetings have resulted in the circulation to Panel Members of a breakdown of the spending and costs in relation to the E+ Smartcard, the amount of income generated by the commercial sponsorship scheme, an explanation of the Urban Traffic Management Control system and information regarding gambling test purchases. In addition, the Panel requested that, if possible, a system to record compliments in addition to complaints be established and that the Director of Children, Young People and Learning re-establish the former schools environmental focus group consisting of education and environment officers. The next meeting of the Panel is taking place on 24 June 2014.

Health O&S Panel

5.10 The Panel met on 7 January, 4 February and 13 March. The main items considered at those meetings included:

- Receiving submissions from members of the public under the Public Participation Scheme for Overview and Scrutiny.
- Reviewing the quarterly performance reports of the Adult Social Care, Health and Housing department, relating to public health.
- A progress briefing on Public Health activities and the Public Health Survey.
- An update on the Government's plans for the further integration of Health and Social Care.
- The Public Health element of the Council's Draft Budget Proposals for 2013/14.
- Adopting the report of the Panel's Working Group which reviewed the lessons of the report by Robert Francis QC for Health O&S. One important recommendation was to improve the quality of the Panel's work by co-opting in people with expert knowledge of the medical world; we were pleased that the Commission subsequently co-opted onto the Panel a retired GP, Dr David Norman whose participation is very valuable.
- Meeting Heatherwood and Wexham Park Hospitals NHS Foundation Trust concerning their actions on the inspection reports issued on both hospitals by the Care Quality Commission (CQC). We subsequently drew our concerns formally to the attention of the Trust, NHS England, Monitor and the CQC. The Trust has since been judged as 'Inadequate' by the CQC and put into 'Special Measures' by Monitor.
- Meeting the Royal Berkshire Hospital NHS Trust, with particular reference to their services to residents of Bracknell Forest, the cancer and renal services facility at Brants Bridge, and the actions taken to reduce Accident and Emergency waiting times.
- Receiving a briefing on the role and activities of SEAP Complaints Advocacy Service.
- The results of the December 2013 GP Patient Survey for Bracknell Forest GP Practices, and information from the NHS Choices website, for the NHS Foundation Trusts providing most NHS services to Bracknell Forest residents.

5.11 At each of its meetings, the Panel also considered scheduled Executive Key and Non-Key Decisions relating to Health, and monitored the progress of its Working Group.

5.12 Between formal meetings, the Panel's activities have included, for example:

- Participating in the February meeting of the Thames Valley Health O&S Network, facilitated by the Centre for Public Scrutiny.
- Attending the opening of the new Urgent Care Centre in Bracknell in April 2014.
- Providing comments on the 2013-14 NHS Quality Accounts for two NHS Trusts serving Bracknell Forest residents.
- Attending the CQC's 'Quality Summit' on the outcome of their inspection of Wexham Park Hospital, and the ensuing actions required by the Trust and Monitor.

5.13 The Panel's next meeting on 3 July.

Joint East Berkshire with Buckinghamshire Health O&S Committee

5.14 This Committee, formed jointly with Slough Borough Council, the Royal Borough of Windsor & Maidenhead, and Buckinghamshire County Council has remained suspended, the last meeting having been held in March 2013. The O&S Commission had previously decided to end the Council's involvement in the Joint Committee, unless there is a need to respond to a statutory consultation affecting health services in East Berkshire.

Children, Young People and Learning O&S Panel

5.15 Meetings of the Panel took place on 15 January and 5 March, 2014. During the meetings the Panel considered and commented on:

- The minutes and Annual Report of the Corporate Parenting Advisory Panel.
- Quarterly Service Reports (QSRs) for the relevant quarters.
- The Council's draft budget proposals 2014/15.
- Bracknell Forest Local Safeguarding Children Board (LSCB) Annual Report 2012/13.
- Annual Review of the Children and Young People's Plan.
- Self Assessment against the Department for Education Statutory Guidance on the Roles and Responsibilities of the Director and Lead Member of Children Services.
- Child Poverty Strategy – Progress and Next Steps.
- Local Healthwatch Protocol.
- Bracknell Forest Strategy for 'Narrowing the Gap' (NtG) in performance between pupils eligible for the Pupil Premium and their peers.
- Support for children with English as an additional language.
- Children missing from education.
- Education Transport Policies.
- O&S Work Programme 2014-15.
- Six monthly O&S progress report.
- Scheduled Executive key and non-key decisions.

5.16 The Panel monitored progress achieved by its working group reviewing the planning and provision of school places which was completed in May 2014 and the resulting report will be considered by the Panel at its next meeting, on 11 June 2014. The Panel also established a new working group to commence a future review of the impact of substance misuse on children, young people and their families (see Appendix 1).

5.17 Activities between Panel meetings included receipt of updates on the progress being made to re-establish links between the LSCB and Adult Safeguarding Boards and the voluntary and community sector, on the number of applications to become foster carers received and the percentage of successful selections, and on the number of children and young people successfully completing drug treatment. In addition, the Panel requested that narrative be added to future QSRs to indicate the number of agency staff employed to fill recruitment vacancies ranging over the quarter and the number and type of placements for foster care; that the action plan associated with the draft NtG strategy be expanded to address transition issues; and that the Director of Children, Young People and Learning reconsider the aspect of the Education Transport Policy requiring a member of school staff to accompany a secondary school pupil to and from their transport vehicle.

Adult Social Care and Housing O&S Panel

5.18 The Panel met on 14 January and 25 March, 2014. The main items considered at the meetings were:

- Quarterly Service Reports for the relevant quarters.
- The Council's draft budget proposals 2014/15.
- Modernisation and Transformation of Older People's Services.
- Service Plan 2014/15 Revised Key Actions and Indicators.
- Learning Disabilities Commissioning Strategy 2014-2019
- Bracknell Forest Joint Commissioning Strategy for Dementia 2014-2019
- Better Care Fund – Integration of Health and Social Care.
- Local Healthwatch Protocol.
- O&S Work Programme 2014-15.
- Six monthly O&S progress report.
- Scheduled Executive key and non-key decisions.

5.19 The Panel monitored progress achieved by its working group reviewing the Council's role with regard to care governance and managing safeguarding in regulated Adult Social Care Services (see Appendix 1).

5.20 Actions arising from Panel meetings have resulted in the circulation to Panel Members of further information on investments in Icelandic banks and the impact of the return of monies to the Council, figures on the number of people with mental health issues supported by Adult Social Care Services, and information on how long people receiving benefits from the Council have to notify it of an overpayment of benefits. The next meeting of the Panel is taking place on 17 June 2014.

Other Overview and Scrutiny Issues

5.21 The 2013/14 Annual Report of O&S, incorporating the 2014/15 work programme, was adopted by Council at its meeting on 30 April 2014.

5.22 Responses to the feedback questionnaires on the quality of O&S reviews are summarised in Appendix 2, showing a consistently high score across the various questions posed.

5.23 Quarterly review and agenda setting meetings between O&S Chairmen, Vice-Chairmen, Executive Members and Directors are taking place regularly for the Panels (every two months for the O&S Commission).

5.24 The Council's entry, *'Transforming the effectiveness of health scrutiny by applying the lessons of the Francis Report',* was shortlisted for this year's 'Good Scrutiny Awards' by the Centre for Public Scrutiny.

5.25 The Head of O&S continued to represent South East councils' O&S interests on the National O&S Forum, run by the CfPS, though due to pressure on the CfPS's resources, they have decided to suspend meetings of that forum until 2015.

6 Developments in Overview and Scrutiny

6.1 There have been no notable national or local developments in O&S in the period covered by this report.

7 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Statutory Scrutiny Officer

7.1 The monitoring of this function is carried out by the Statutory Scrutiny Officer on a quarterly basis. Good progress has been made on the agreed programme of work by Overview and Scrutiny for 2013/14. Scrutiny Panels have continued to focus on areas of importance to local residents, and the quality of the work done continues to be high.

Borough Solicitor

7.2 Nothing to add to the report.

Borough Treasurer

7.3 There are no additional financial implications arising from the recommendations in this report.

Equalities Impact Assessment

7.4 Not applicable. The report does not contain any recommendations impacting on equalities issues.

Strategic Risk Management Issues

7.5 Not applicable. The report does not contain any recommendations impacting on strategic risk management issues.

Workforce Implications

7.6 Not applicable. The report does not contain any new recommendations impacting on workforce implications.

Other Officers

7.7 Directors and lead officers are consulted on the scope of each O&S review before its commencement, and on draft O&S reports before publication.

8 CONSULTATION

Principal Groups Consulted

8.1 None.

Method of Consultation

8.2 Not applicable.

Representations Received

8.3 None.

Background Papers

Minutes and papers of meetings of the Overview and Scrutiny Commission and Panels.

Contact for further information

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Doc. Ref

CXO\Overview and Scrutiny\2014-15\progress reports

Appendix 1

OVERVIEW AND SCRUTINY CURRENT WORKING GROUPS – 2014/15
Position at 20 May 2014

Overview and Scrutiny Commission								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Business Rates	Angell (Lead), Heydon, Leake and Virgo	Alan Nash	Richard Beaumont					First meeting held on 19 May 2014

Health Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Francis Report on NHS Mid Staffordshire Hospital	Mrs McCracken (Lead), Mrs Angell, Angell, Baily, Kensall, Mrs Temperton, and Virgo	Glyn Jones	Richard Beaumont	√	Completed	√	Executive response received. Responses due from two NHS Trusts	The agreed changes to O&S practices are partly implemented

Environment, Culture and Communities Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Cultural Services Offering	Finnie (Lead) Brossard, Ms Brown, Gbadebo and Thompson	Mark Devon	Richard Beaumont	√	Information gathering around 50% completed.			Next meeting arranged for 17 June.

Children, Young People and Learning Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
School Places	Mr Briscoe (PGR) (Lead), Mrs Birch, Kensall and Mrs Temperton	Chris Taylor	Andrea Carr	√	The review has been completed.	In draft		The report of the review will be submitted to the Children, Young People and Learning O&S Panel for approval on 11 June 2014.
Substance Misuse – Children and Young People	Mrs Birch, Mrs Temperton, Mr Briscoe (PGR), and Miss	Jillian Hunt	Andrea Carr		First meeting to take place following the June Panel			The review is yet to commence.

	Richardson (Teacher rep.)				meeting.			

Adult Social Care Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
The Council's Role in Regulated Adult Social Care Services	Harrison (Lead), Mrs McCracken, Mrs Temperton and Thompson	Zoë Johnstone	Andrea Carr	√	The information gathering process is largely completed.			The report of the review is under preparation.

Completed Reviews

Date Completed	Title
December 2003	South Bracknell Schools Review
January 2004	Review of Adult Day Care Services in Bracknell Forest (Johnstone Court Day Centre & Downside Resource Centre)
May 2004	Review of Community & Voluntary Sector Grants
July 2004	Review of Community Transport Provision
April 2005	Review of Members' Information Needs
November 2005	The Management of Coronary Heart Disease
February 2006	Review of School Transfers and Performance
March 2006	Review of School Exclusions and Pupil Behaviour Policy
August 2006	Report of Tree Policy Review Group
November 2006	Anti-Social Behaviour (ASB) – Review of the ASB Strategy Implementation
January 2007	Review of Youth Provision
February 2007	Overview and Scrutiny Annual Report 2006
February 2007	Review of Library Provision
July 2007	Review of Healthcare Funding
November 2007	Review of the Council's Health and Wellbeing Strategy
December 2007	Review of the Council's Medium Term Objectives
March 2008	2007 Annual Health Check Response to the Healthcare Commission
April 2008	Overview and Scrutiny Annual Report 2007/08
May 2008	Road Traffic Casualties
August 2008	Caring for Carers
September 2008	Scrutiny of Local Area Agreement
October 2008	Street Cleaning
October 2008	English as an Additional Language in Bracknell Forest Schools
April 2009	Overview and Scrutiny Annual Report 2008/09

Date Completed	Title
April 2009	Healthcare Commission's Annual Health Check 2008/09 (letters submitted)
April 2009	Children's Centres and Extended Services in and Around Schools in Bracknell Forest
April 2009	Older People's Strategy
April 2009	Services for People with Learning Disabilities
May 2009	Housing Strategy
July 2009	Review of Waste and Recycling
July 2009	Review of Housing and Council Tax Benefits Improvement Plan
December 2009	NHS Core Standards
January 2010	Medium Term Objectives 2010/11
January 2010	Review of the Bracknell Healthspace (publication withheld to 2011)
January 2010	14-19 Years Education Provision
April 2010	Overview and Scrutiny Annual Report 2009/10
July 2010	Review of Housing and Council Tax Benefits Improvement Plan (Update)
July 2010	The Council's Response to the Severe Winter Weather
July 2010	Preparedness for Public Health Emergencies
October 2010	Safeguarding Vulnerable Adults in the context of Personalisation
October 2010	Review of Partnership Scrutiny
December 2010	Hospital Car Parking Charges
January 2011	Safeguarding Children and Young People
March 2011	Review of the Bracknell Healthspace (Addendum)
April 2011	Overview and Scrutiny Annual Report 2010/11
June 2011	Office Accommodation Strategy
June 2011	Plans for Sustaining Economic Prosperity
July 2011	Review of Highway Maintenance (Interim report)
September 2011	Performance Management Framework

Date Completed	Title
September 2011	Review of the Council's Medium Term Objectives
October 2011	Plans for Neighbourhood Engagement
October 2011	Regulation of Investigatory Powers
October 2011	Site Allocations Development Plan Document
January 2012	Common Assessment Framework
February 2012	Information and Communications Technology Strategy
April 2012	NHS Trusts Quality Accounts 2011/12 (letters submitted to five Trusts)
April 2012	Overview and Scrutiny Annual Report 2011/12
June 2012	Commercial Sponsorship
July 2012	Communications Strategy
November 2012	Proposed Reductions to Concessionary Fares Support and Public Transport Subsidies
November 2012	Modernisation of Older People's Services
January 2013	Preparations for the Community Infrastructure Levy
February 2013	Substance Misuse
February 2013	'Shaping the Future' of Health Services in East Berkshire
April 2013	Overview and Scrutiny Annual Report 2012/13
April 2013	NHS Trusts Quality Accounts 2011/12 (letters submitted to three Trusts)
July 2013	School Governance
September 2013	Delegated Authorities
October 2013	Bracknell Forest Bus Strategy
January 2014	Applying the Lessons of the Francis Report to Health Overview and Scrutiny
April 2014	Overview and Scrutiny Annual Report 2013/14

Appendix 2

Results of Feedback Questionnaires on Overview and Scrutiny Reports

Note – Departmental Link officers on each major Overview and Scrutiny review are asked to score the key aspects of each substantive review on a scale of 0 (Unsatisfactory) to 3 (Excellent)

	Average score for previous 20 Reviews[1]
PLANNING Were you given sufficient notice of the review?	**2.9**
Were your comments invited on the scope of the review, and was the purpose of the review explained to you?	**2.9**
CONDUCT OF REVIEW Was the review carried out in a professional and objective manner with minimum disruption?	**2.7**
Was there adequate communication between O&S and the department throughout?	**2.8**
Did the review get to the heart of the issue?	**2.6**
REPORTING Did you have an opportunity to comment on the draft report?	**2.9**
Did the report give a clear and fair presentation of the facts?	**2.6**
Were the recommendations relevant and practical?	**2.6**
How useful was this review in terms of improving the Council's performance?	**2.6**
Overall average score	**2.7**

[1] Road Traffic Casualties, Review of the Local Area Agreement, Support for Carers, Street Cleaning, Services for Adults with Learning Disabilities, English as an Additional Language in Schools, Children's Centres and Extended Services, Waste and Recycling, Older People's Strategy, Review of Housing and Council Tax Benefits Improvement Plan, 14-19 Education, Preparedness for Public Health Emergencies, Safeguarding Children, Safeguarding Adults, the Common Assessment Framework, Modernisation of Older People's Services, Community Infrastructure Levy, School Governance, Delegated Authorities, and Applying the Lessons of the Francis Report.

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
3 JULY 2014

EXECUTIVE KEY AND NON-KEY DECISIONS RELATING TO HEALTH
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report presents scheduled Executive Key and Non-Key Decisions relating to Health for the Panel's consideration.

2 RECOMMENDATION

2.1 That the Health Overview and Scrutiny Panel considers the scheduled Executive Key and Non-Key Decisions relating to Health appended to this report.

3 REASONS FOR RECOMMENDATION

3.1 To invite the Panel to consider scheduled Executive Key and Non-Key Decisions.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

5.1 Consideration of Executive Key and Non-Key Decisions alerts the Panel to forthcoming Executive decisions and facilitates pre-decision scrutiny.

5.2 To achieve accountability and transparency of the decision making process, effective Overview and Scrutiny is essential. Overview and Scrutiny bodies are a key element of Executive arrangements and their roles include both developing and reviewing policy; and holding the Executive to account.

5.3 The power to hold the Executive to account is granted under Section 21 of the Local Government Act 2000 which states that Executive arrangements of a local authority must ensure that its Overview and Scrutiny bodies have power to review or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are the responsibility of the Executive. This includes the 'call in' power to review or scrutinise a decision made but not implemented and to recommend that the decision be reconsidered by the body / person that made it. This power does not relate solely to scrutiny of decisions and should therefore also be utilised to undertake pre-decision scrutiny.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

No advice was sought from the Borough Solicitor, the Borough Treasurer or Other Officers or sought in terms of Equalities Impact Assessment or Strategic Risk Management Issues. Such advice will be sought in respect of each Executive Forward Plan item prior to its consideration by the Executive.

7 CONSULTATION

None.

Background Papers

Local Government Act 2000

Contact for further information

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HEALTH OVERVIEW & SCRUTINY PANEL

EXECUTIVE WORK PROGRAMME

REFERENCE	I045424

TITLE: Berkshire Wide Joint Agreement for Public Health Services

PURPOSE OF DECISION: To request approval to extend the existing joint agreement between the 6 Berkshire authorities to procure Public Health contracts. This relates to all Wards in Berkshire.

FINANCIAL IMPACT: Within existing budget

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: Representatives from all 6 Berkshire Authorities

METHOD OF CONSULTATION: Meetings and discussions with interested parties

DATE OF DECISION: Not before 1 Jun 2014

REFERENCE	I046694

TITLE: Approval of specifications and procurement plans in relation to sexual health services

PURPOSE OF DECISION: Services aimed at improving Sexual Health are currently being reviewed with the intention of recommissioning them in a form that best matches local need from the start of 2015/16. The results of the review and financial modelling will be presented and a recommendation made for ongoing commissioning.

FINANCIAL IMPACT: Within existing budget (Public Health grant)

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: A range of stakeholders including local representatives of
healthcare providers, schools, youth services and council members.

METHOD OF CONSULTATION: A number of meetings have taken place in order to allow consultation on the recommissioning of these public health services.

DATE OF DECISION: 24 Jun 2014

REFERENCE	I046696

TITLE: Commissioning of Sexual Health services

PURPOSE OF DECISION: Services aimed at improving Sexual Health and have been reviewed with the intention of commissioning them in a form that best matches local need from the start of 2015/16. The results of the review and financial modelling will be presented and a recommendation made for ongoing commissioning.

FINANCIAL IMPACT: Within existing budget (Public Health grant)

WHO WILL TAKE DECISION: Executive

PRINCIPAL GROUPS TO BE CONSULTED: A range of stakeholders including local representatives of
healthcare providers, schools, youth services and council members.

METHOD OF CONSULTATION: A number of meetings have taken place in order to allow consultation on the recommissioning of these public health services.

DATE OF DECISION: 24 Jun 2014

REFERENCE	I046863

TITLE: Community Mental Health Support Services Procurement Plan

PURPOSE OF DECISION: To approve the proposed Procurement Plan to allow for a competitive tender process for Community Mental Health Support Services.

FINANCIAL IMPACT: To be incorporated into the report

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: Internal teams within Adult Social Care who are part of the project team, the current provider of the service, people using the current service and their carers.

METHOD OF CONSULTATION: Meeting(s) with staff and people supported by the service

DATE OF DECISION: 24 Jun 2014