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.