Governor Questions Log

No.	Date	Governor	Query	Response
176	25 April 2024	Sunila Lobo	1) The community have heard about 10 month waits for non-melanoma skin carcinomas, which is forcing frightened patients to private treatment. Can Governors seek assurance that Dermatology is taking appropriate action to reassure patients and have set targets to reduce waits towards reducing potential deterioration of patients' conditions?	The Dermatology team offer an extremely comprehensive Advice and Guidance (A&G) service where all GPs are able to contact the team with questions/queries/concerns and the team aim to reply to them within 3-7 working days. The GPs have fed back that they find this service invaluable. On average the Trust receives 30-50 requests per day to respond to. The team are often able to suggest treatment for the less urgent skin lesions (and rashes) for primary care colleagues to try in the community which can often mean the patient does then not need to be seen in clinic. This A&G process also means they are able to contact us if they have concerns about a lesion growing, send us photographs to review and expedite it. The Dermatology team haven't specifically contacted patients with regards to waiting times to reassure them but they are comparable (or even better) to many of our surrounding counties. We have also set up several initiatives to try and improve things and reduce our waiting times. These include but not exclusively: • Recently employed a trust locum consultant (March 2024) • Planning on employing another trust locum if a suitable candidate applies to our recent advert (advert closed this week) • 12 month GP education outreach programme to try and educate GPs and other primary care clinicians • Employing a dermatology pharmacist to see a certain cohort of patient and free up dermatologists to see more skin cancer and complex dermatology cases • Running extra Saturday clinics to undertake skin cancer reviews and dermatology surgery procedures • Looking at external providers
			2) RBH's 4 hours or less waiting times	The percentage of waits in the Emergency Department (ED) over 5 hours

			at A&E are at 69% of the targeted 76/78%. There is evidence that A&E waits of 5 hours or more can lead to significant deterioration or even death. What percentage of waits at A&E are 5 hours and more? Can Governors seek assurance that RBH will be taking action to achieve its waiting time target and by when is this hoped to be achieved?	between January and May 2024 is an average of 26% (including eye casualty). The Trust has a strong focus on improving waiting times in the Emergency Department (ED), monitored through the trust-wide improvement programme Improving Together, along with initiatives to improve hospital flow and length of stay through ED and the organisation. There are also a number of initiatives to support the reduction in waiting times outside of ED including support from Berkshire West Place, in commissioning of an onsite Urgent Care Centre from October 2024 to increase same day access for patients attending with minor illness and to support meeting the demand for primary care.
			3) In a National long-term plan, a target of reducing the stillbirth rate by 50% by 2025 was set. Can Governors seek assurance on the actions taken or to be taken to achieve this target?	Reducing perinatal mortality is one of the main priorities for maternity services at the Trust. The specific initiatives for reducing perinatal mortality are grouped together under the umbrella of the Saving Babies Lives Care Bundle (NHSE version 3 published in May 2023) The bundle contains standards for the following: 1. Reducing smoking in pregnancy 2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction 3. Raising awareness of reduced fetal movements 4. Effective fetal monitoring during labour 5. Reducing preterm birth 6. Management of diabetes in pregnancy Each of these elements has multiple standards. Compliance with these standards is monitored quarterly through the organisation governance processes and externally through the LMNS Board (Local Maternity and Neonatal System within the ICB) Ultimately our partners at the LMNS confirm and assess our progress and compliance. The latest quarterly report

				(Q4) confirmed that we are fully compliant.
177	9 May 2024	Benedict Krauze	What is the Trust's process for keeping patients informed as to their date for surgery including support for managing their condition whilst they are waiting e.g. pain management? Are they provided with a contact number that they can call to get an update rather than going to their GP. Also, what specialities are covered by Health Coaches.	Each specialty at the Trust has its own Clinical Administration Team (CAT) that patients are able to contact for updates related to their pathway, although each department will have their own processes for updating patients/providing additional support contact details and material for advice. The contact number for the individual CAT is listed on all correspondence letters to the patient as well as available via the Trust website under the department. The Trust has Health Coaches that screen in-patients in Trauma & Orthopaedics and Colorectal Cancer to support them. In addition, we have a transitional pain service for patients who are picked up as needing specialist pain support by our Health Coaches.
178	3 June 2024	Paul Williams	We would like to know the average waiting time from referral to operation for both hip and knee replacement. Reading has been suffering from water supply outages for a few days not only affecting Tilehurst - Pangbourne but much nearer to the RBH in Redlands (Alexandra Road). Most organisations have contingency arrangement for power cuts but not water supply failure. What assurances have you received about contingencies the RBH has and does this appear on the risk register?	The average wait for hip & knee from referral to surgery is currently 61 weeks. However, this could vary depending on urgency, availability for cancellations or complexity of the procedure. The Trust has business continuity plans for all departments. The Trust does have arrangements for water, unfortunately the incident this relates to (that affected wide parts of Reading) was a water supplier issue and their own communication and contingency arrangements failed. Senior level improvement meetings were held between RBFT, Thames Water and Berkshire Healthcare CT (also affected) to ensure changes are made and since the incident the Trust now has a clear arrangement with Thames Water for water supply disruption resolution. The Trust also contingency and resilience plans for power with generator back up. Both electricity and water supply are on the Estates & Facilities risk register.
179	14 June	Paul	1. Is it possible for a doctor to sign a DNACPR even if the patient	1. It is possible but not recommended and the doctor concerned would need to state that this was the case and their reasons

	2024 8 August 2024	Williams	disagrees? 2. What the doctor should do? e.g explain CPR - what it includes and the possible side effects and if it is medically appropriate 3. Can patients seek a second opinion? 4. Is information on this topic available on the Trust's website? 5. Should the patient at first discuss DNR with his/her GP?. 6. Is CPR not appropriate for older (define 65+?) and frail people or people who have a serious illness and is near to end of life 7. The experience of a number of patients has been different, so what assurance can be given to show there is oversight in the process to ensure a consistently correct handling of DNR? 8. Is the guidance and information contained on www.resus.org.uk recommended by the RBH.	for doing so. 2. Yes all of these. As with all medical consent what the pros and cons might be and to anticipate and answer any questions the patient might have 3. Yes 4. Information was on the old Trust website but was not carried forward when the new website was implemented. The resus team are working with Comms to get this information republished. A draft version has been produced and is awaiting approval by the Resus team. In due course, a section of the website called 'your stay in hospital' in which this information will be made available. Ahead of this it will be on the visitors' section of the website. 5. Not necessarily and in the current times, this may be difficult 6. There is no age limit. It relates to how likely CPR would be successful and whether it might be the right thing to do for that patient at that stage of life. It should always be an agreed decision between the patient (and often their close family) and the clinical team caring for them. The decision may change with time as the patient's condition changes. 7. We undertake an annual audit of the ReSPECT documentation which is cascaded to all teams. We also undertake a microaudit on a monthly basis of patients with a current DNACPR to check whether they have an associated ReSPECT form that has been formatted correctly and if we find gaps we address these with the teams. • We facilitate a talking DNACPR with ReSPECT course which enables staff to have these conversations we also have an SOP for specialist practitioners to also be able to document these decisions.

				• We undertake ward based training and have a footprint on doctors induction to share the message as widely as possible. • We have links with the regional team looking at how Connected Care can best be utilised so that the ReSPECT form is visible both in hospital and in the community setting so that we are sharing this information as widely as possible. • We have good links with the PALS team to enable us to address any concerns raised by patients/families with regards to ReSPECT decisions and we will make contact address these directly which, on the whole, is very well received. 8. Yes. The Trust recommends the guidelines contained on www.resus.org.uk
180	19 June 2024	John Bagshaw	Following the recent Mail article Scandal-hit hospital where celebrity make-up artist died from sepsis is accused of 'putting lives at risk' by having unqualified medics covering doctors' shifts in A&E Is the Trust limiting the use of PAs in the emergency department (as in some other Trusts) and are any used in paediatric emergency cases?	There is a very clear code of practice set by the Faculty of Physician Associates, and rigorous governance around the work of our Physician Associates (PAs). We do not use PAs in place of doctors and we ensure that they can practice safely. They are also subject to dedicated training and thorough competency-based assessments to monitor the safety and standard of their work which is also subject to stringent supervision from appropriate clinical colleagues. We have a strong track record on the use of PAs who bring added value to our multi-disciplinary teams. We currently employ more than 40 PAs who play key roles across a wide range of services including Emergency Department and Paediatrics. Physician Associates are a valued and integral part of our multi-disciplinary teams and their input in enhancing patient care cannot be underestimated.
181	10 July 2024	Bill Murdoch	Governor raised an issue in relation to cark	NHS Property Services who own the building and car park at Townlands

			parking at Townlands Memorial Hospital	Hospital is aware of the issues with car parking and are in active discussions with the relevant parties to address the issues. The Trust has asked NHS Property Services for updates as these discussions progress.
182	16 July 2024	Alice Gostomski	A query was raised as to whether the Endoscopy outpatient team were able to call patients to attend when an outpatient slot became available due to another patient not attending at short notice.	Yes the team can and do fill short notice cancellations in outpatients, a vacant slot list is pulled from EPR to identify the slots and patients are called to fill them. However, this is very dependant of staffing level within the Clinical Admin Team (CAT).
183	10 October 2024	Paul Williams	Patient Transport non-emergency service. This is a contract which is let by the RBH and is currently with South Central Ambulance Serices (SCAS). It has been suggested that this service has been re-tendered and has gone to another provider. Can you confirm that this is the case and whether there will be any changes to the service provided by SCAS?	The Trust's Non-Emergency Patient Transport contract was put out to tender last year. A new contract was awarded to Alpha Ambulances in November 2023 with a commencement date of January 2024 to allow for mobilisation. The contract features enhanced requirements, covering all aspects of the service to ensure the highest standards of patient care are maintained throughout.
184	11 October 2024	Paul Williams	Patient Transport non-emergency service. Governor asked for examples of the enhanced service or a link to where it might be found?	As part of the enhanced offer this contract provides ambulances to be based on site at the Trust from 10am to 10pm on weekdays and from 10am to 8pm at weekends. These vehicles are on call to take discharged patients home, as instructed by the Trust. Additional vehicles are made available to transport any discharged patients that live out of area, on an 'as needed' basis. All staff are suitably trained by the contractor and work to agreed Trust protocols.
185	14 October 2024	Beth Rowland	Does the Trust have the equipment to carry out non-invasive autopsies for children or are we planning to purchase equipment in	Response awaited from internal team

			the near future?	
186	30 October 2024	Bill Murdoch	If someone is taking an injured or very sick person to A&E can they take that patient by private car to the door of A&E ? The access to A&E off Craven Rd says positively ambulances only. However, if the driver of the car can only find a space in the main car park at a high level (i.e. the half dozen 30 min spaces are occupied) it obviously would be totally unreasonable to expect an urgent injured person to be carried to A&E. In these cases the private car is surely acting as an ambulance in these circumstances. Patients are also aware that invariably there are private cars parked in the spaces to the side of A&E's entrance	All parking spaces can be used as an emergency drop off. The Trust does not have dedicated 30 minute spaces anymore. After the 30 minutes if the vehicle is not authorised to park there, then they could receive a Parking Charge Notice (PCN). However, charging for parking in any of the car parks only starts after 30 minutes. A private car cannot act or assume the responsibility of an ambulance and a private ambulance would need to be insured as such. Parking spaces set aside from the A&E along east drive are primarily for the pharmacy deliveries and collections and we also have on-call consultant parking in that location. We are aware that members of the public do try to use these spaces. However, they could receive a PCN if they do so.
187	30 October 2024	Benedict Krauze	A Governor raised a query as to the cost of heating and lighting for the Trust.	For the period 1st April 2023 to 31st March 2024 the total cost of heating was £1,627,168.80. For the period 1st April 2024 to 31st March 2025 the total cost of heating will be £1,006,015.80. The Trust does not yet have sub-metering to identify lighting costs from electrical consumption.
188	12 November 2024	Sunila Lobo	I had a recent experience of a Muslim member of the community who had just lost his dad contacting me to find out who to get	The correct process was followed whereby the GP was contacted by the family and the process was able to proceed. Opening hours for the Medical Examiners Service, to the public is Monday

			in touch with at the hospital at 5.15pm on a Friday, in order to get his late dad's death certificate/post-mortem completed quickly. This is because the funeral rites and burial need to be performed asap. Islamic religious law calls for the burial of the body as soon as possible after the cause of death is known. The body is buried usually the same day as the death. I called the Medical Examiner's number that I found on the RBH website but to no avail (it went to voicemail). The bereaved son's distress was very concerning to me. To cut a long story short, their GP was available when contacted and the process was able to proceed. Question: What is the process at RBH for such an occurrence? Especially, out of hours?	to Friday, 9am -5pm. There is an out of hours service available where the on call Medical Examiner can be contacted by the via switch between the hours of 8am - 10am every Saturday, Sunday and bank holidays. This out of hours provision has been made available to all our stakeholders including GPs in Berkshire West, all Staff at the Trust. The ME service also provided information to our Buddhist, Christian, Hindu, Jewish, Muslim and Sikh faith leaders in the local area.
189	26 November 2024	Richard Havelock	1) Given what seem to be the repeated occasions when the car parking monitoring system has broken down and penalty notices have been issued incorrectly, what action has been taken to investigate why these mistakes have been made, and how they can be prevented in future? In addition, can assurance be given that (a) that an apology will be made to anyone sent a penalty notice in	1) The few times the ANPR system has had issues, APCOA and the Trust have investigated the situation and responded accordingly. Once an issue has been found, systems and practices are put in place to rectify this and ensure it is not repeated. APCOA do send apology letters to anyone that has received a PCN by mistake. Should APCOA fail to operate as per the contractual conditions, sanctions would be imposed. 2) The Trust receives the income from parking fines issued for non-compliant parking which has a negative impact on safety or other users, or for non-payment. The income is ring-fenced and used

			error, and (b) appropriate sanctions will be imposed on the management company if it fails to comply? 2) In addition, who receives the proceeds from the fines?	solely to fund physical improvements to travel and transport related facilities, for all modes of transport.
190	26 November 2024	Richard Havelock	A patient with urinary incontinence living in South Oxfordshire, who has been treated at the Royal Berks, was visited recently by a domiciliary nurse to change a catheter bag. Unfortunately it was found that its inlet was of a different gauge from the tubing already in place, and so it was not possible to connect it, and he was left without any bag for a time. I do not know where the nurse was based, but there is clearly a need to standardise across the area covered by the various NHS bodies. What is being done to achieve this?	There is a Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) wide project underway to standardise supplies and create a formulary across the system. At present the Trust refer to Berkshire Healthcare Foundation Trust's (BHFT) Continence Advisory Service (CAS) for supplies and would normally order the same supplies as the patient was discharged with. For patients who are independent with bag changes the CAS would contact the patient directly on discharge and liaise with the GP to source the supplies. However, if a patient requires support with bag changes a District Nurse (DN) referral would be completed to the HUB for DN visits.
191	27 January 2025	Sunila Lobo	There is no information about the Trust's Virtual Wards service on the Trust website. As such, the following questions have been formulated around referral criteria, consent, quality control, workforce and assessment/re-assessment in order to seek assurance about the provision of this service to members and the wider public: 1) For patients who live alone or with a carer with reduced capabilities, what criteria	1) Patients are assessed in a holistic manner and if appropriate to be clinically managed in our Virtual hospital, the Trust assesses their individual circumstance to ensure that their care needs can be met by themselves, their carer and/or support services in place. 2) Yes, patients are informed about their suitability for one of our Wards with verbal informed consent obtained. 3) The virtual team are not able to provide nursing care, therefore patients suitability to maintain nutrition, hydration (ADL's) is decided based on the availability of existing care services in place. Whether

			are applied before they are assigned to the virtual ward? 2) Are all patients assigned to the virtual ward asked for their consent to that form of treatment? 3) For patients who live alone or with a carer with reduced capabilities and who are assigned to the virtual ward, what arrangements are made for nutrition, hydration, observation of deterioration, toileting, personal care? 4) It has been observed that some patients referred by their GP to the RBH AMU, when there is no bed available, have been assigned to the virtual ward. Is this assignment subject to the same criteria and arrangements as other routes to the virtual ward? 5) Are monitoring calls to patients in the virtual ward recorded? Is there quality control of these calls? 6) What about an in-home medical assessment once a patient is assigned to a virtual ward? Is there quality control of these visits/assessments?	that be from an informal/formal carer or indeed through care packages. Patients that require new packages of care are unable to be admitted until such time that care is in place. Patients with significant mobility issues/frailty, can also be supported by our virtual at home services to reduce the need for transfer to the virtual clinic if needed to do so. In regards to the patients clinical condition and trajectory, the virtual team will ensure the required monitoring equipment is available to the patient, they are shown how to use it and how to report any changes that may occur outside of a scheduled clinical interaction. 4) There may be individual patients that are redirected from AMU to the Virtual Ward if their clinical management could be best facilitated by the virtual team. However, no patient has been referred to our virtual team as a result of no bed being available. All patients are managed in the most appropriate team according to their clinical need. 5) Our telecommunication services are not currently recorded. However, conversations and discussion are recorded within the patient electronic record the same way it would to patient interaction in the ward environment. 6) We care for patients in 3 distinct ways, firstly in a remote fashion, utilising telecommunications and technology. Secondly, if in need for a patient to undertake physical assessment, diagnostics or treatments, patient can be transferred to the Virtual Ward clinic. In circumstances that it is in the best interest of a patient to not be transported, the virtual team can provide at home assessment, diagnostics and treatments in their place of residence. 7) The workforce for Virtual hospital is based on a Multi-Disciplinary Team (MDT) approach to ensure that the right clinician is supporting

			7) What is the workforce of the virtual ward? Is it the same thing as the BHFT frailty virtual ward? 8) When is a re-assessment considered necessary, that is, what is the criteria to evaluate whether a virtual ward ceases to be the best option for the patient?	the right patient, and in turn the clinical team are support by support services. Berkshire Healthcare Foundation Trust (BHFT) run their own model of workforce to suit the need of its patient cohort. 8) When a patients clinical needs are unable to be met by the virtual team, management is transferred to the most appropriate team. This may be through the emergency department or through direct transfer to an in-patient ward. However, this would be facilitated by the Virtual team to maintain patient safety.
192	11 February 2025	Sunila Lobo	1) When will the information in relation to Virtual Wards services be on the Trust website? 2) Can you explain what is meant by: A) "virtual at home services" B) "virtual clinic" C) "virtual team" 3) Further, are these clinical interactions recorded? For training and other purposes.	Following the 2 year National Transformation programmes conclusion on 31 April 2024, the RBFT made steps to fund the service, moving it to BAU for 2024/25 in order to continue the valuable impactful work it has been carrying out. Whilst the budgeted position of the Trust is challenging, the Virtual Hospital Service (VHS) continues to be an active part of the Trust strategy for 2025/26. The commissioned activity target is for an 80 patient caseload per day, this was stretched to 124 with various additionally funded schemes that are not part of the 2025/26 draft budget. No cut in the VHS budget is predicted at this stage, however we are returning to our commissioned level and actively exploring the least impactful services/pathways to reduce or stop.'
193	25 February 2025	Adrian Mather	The citation for the "Cianna's Smile" charity specifically identified that many young people who may be carriers of the sickle cell gene are un-aware of their carrying this gene. Is there anything that Royal Berks Hospital can do to help improve the screening and therefore awareness of this	Screening for sickle cell disease has been part of the national newborn bloodspot screening programme since 2006. https://www.gov.uk/government/publications/handbook-for-sickle-cell-and-thalassaemia-screening/newborn-screening#newborn-screening-results All babies are therefore screened and if identified to be a carrier the family should be notified by 6wks of age. This would have been in place for anyone

			sickle cell gene?	up to the age of 19. For those over the age of 19 screening takes place antenatally for women who are pregnant, again as part of a national screening programme. Patients presenting with symptoms suggestive of sickle cell would be tested as part of a diagnostic workup. We are not commissioned to provide this outside of the national programmes.
194	26 February 2025	Paul Williams	1) Does the contract with Rowlands Pharmacy at the RBH, ask for generic equivalents to be identified and prescribed to patients? Is there a feedback mechanism from the pharmacy to prescribing staff and doctors explaining the generic alternatives? 2) Rowlands directs patients to go their GP to prescribe if the drug is not in their FORMULARY. The GP's pharmacist has to find the generic equivalent if it is not in their FORMULARY (which happened in this example). This leads to delay in the drug being used by the patient.	1) Rowlands follow our regional best value procurement contract that prioritises best value medication brand/product to procure. As a secondary care organisation prescribing on the electronic prescribing record, pharmacists have increased ability to supply from local contracts/formulations, this is different compared to FP10 issues in community. Therefore prescribers do not need to prescribe by generic/brand for a product as we will default to supplying the best value product, unless by exception there is a clinical reason to not do so. Rowlands can feedback to prescriber if there is a particular issue, but they would follow the same contracts that we do within RBFT. 2) We have an internal non-formulary process that Rowlands should be following. A non-formulary approval is required for the drug to be ordered and supplied. This may take a day or so to come in. They shouldn't be referring patient to their GP to supply this drug as it should come from the trust. I can follow this up with Rowlands.
195	26 February 2025	Public Member	I have heard it said elsewhere that patient complaints are like gold dust. Some patients are afraid to put in a complaint, and defensiveness in an institution can prevent the patient's valid issues being appreciated. I spoke with someone who put in a well-	The Trust investigates around 30 complaints and around 250 PALS enquiries each month. Complaints are kept separate from clinical records and are investigated by clinical staff who have not been involved in the patient's clinical treatment in order to maintain impartiality and so care is in no way impacted. Due to the volume of PALS concerns raised, we have introduced a new process to ensure effective closure and escalation for

			written complaint by email to PALS, had no acknowledgement, so tried to phone PALS, succeeded in getting through only on the 5th attempt, then to be told that the person who dealt with complaints was away and would call next day and that there was a long backlog of complaints. My question is - is the RBH getting the value out of patient complaints via PALS	more complex concerns from PALS. We monitor and report weekly on the number of open PALS, and the complaints are reported on monthly for oversight. All complaints are thematically reviewed to understand any key areas for organisational learning, action plans are created for all areas where learning is identified, these actions are tracked and monitored through care group.'
196	18 March 2025	Sunila Lobo	There has been mention at a Public Board about the issue of the audibility of the calling of names at the A&E waiting room. This is particularly concerning for those with hearing loss. Further, the fear of missing a call-out creates anxiety. Has this been resolved as yet?	If someone is hard of hearing or unable to mobilise quickly- reception note this next to the patients name so the clinical staff are aware when calling and admin staff note when they notice people going outside. Staff will go outside to check for patients when calling if no answer and will call 4 times before it is thought that they have self-discharge.