Care Quality Commission

University Hospital Southampton NHS Foundation Trust

Southampton General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement	🟠
Urgent and emergency services	**Good**	🟢
Medical care	**Good**	🟢
Surgery	**Requires improvement**	🟠
Critical care	**Requires improvement**	🟠
Services for children and young people	**Good**	🟢
End of life care	**Requires improvement**	🟠
Outpatients and diagnostic imaging	**Requires improvement**	🟠

Summary of findings

Letter from the Chief Inspector of Hospitals

Southampton General Hospital is part of University Hospital Southampton NHS Foundation Trust. It is an acute hospital and provides accident and emergency (A&E), medical care, surgery, critical care, children and young people's services, end of life care, outpatients and diagnostic services, which are seven of the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. The eighth core service, maternity and gynaecology services, was inspected at the adjacent Princess Anne Hospital (PAH), and the findings are in the inspection report for that location.

Southampton General Hospital is an acute hospital with approximately 1,300 inpatient beds, and employs over 8,400 staff. It provides a full range of elective and non-elective medical and surgical services to the population of Southampton and South Hampshire. The hospital also provides paediatric and adult care specialist services (with the exception of burns, adult renal dialysis and transplantation) to more than three million people living in southern England and the Channel Islands. Specialist services include cardiac services, oncology, neurosciences, level 3 neonatal intensive care (at PAH), and paediatric intensive care. The hospital is a designated regional major trauma centre for paediatrics and adults. There was not a designated outpatients department; outpatient services were provided and managed by core and specialist services.

The team included CQC inspectors and analysts, doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers. (Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.)

The inspection took place on 9 to 11 December 2014, with unannounced visits between 5 and 15 January 2015.

Overall, we rated this hospital as 'requires improvement'. We rated caring and effective services as 'good'. The hospital 'requires improvement' for safe, responsive and well-led services.

We rated, urgent and emergency services, medical care and children and young people's services as 'good'. We rated, critical care, surgery, end of life care, and outpatients and diagnostic imaging services, as 'requires improvement'.

Our key findings were as follows:

Are services safe?

- National data indicated that the hospital was reporting more incidents than the national average. Staff were encouraged and found it easy to report incidents on the electronic system. The greatest proportion of incidents were low and no harm incidents. Slips, trips and falls and pressure ulcers were the top serious incident requiring investigation (SIRI) and action was being taken to reduce these across the hospital. We found that incidents were investigated and learning shared within services, but learning across services, such as in outpatients, could be improved. The reporting of incidents in diagnostic imaging services was not always robust and transparent.

- In most services there was a culture of openness and transparency when things went wrong, and the hospital was well placed to meet the new regulations relating to Duty of Candour. However, the diagnostic imaging services had not followed this statutory duty when there had been notifiable incidents around patient safety.

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, venous thromboembolism (VTE or blood clots), catheter urinary tract infections (C. UTIs) and falls. The information was monitored throughout the hospital and the results were displayed for the public in clinical areas.

- The hospital was working to reduce the prevalence of pressure ulcers incrementally over time. The trust had a target to reduce levels by 20% over the year; this had not been fully achieved in 2013-14. Hospital data indicated there was a slightly decreasing trend for avoidable grade 2, 3 and 4 pressure ulcers by the end of 2014.

Summary of findings

- The hospital had a zero tolerance for hospital infection rates for MRSA. The MRSA rate was higher when compared to trusts of similar size and complexity but there had been no cases since July 2014. The trust's infection rates for C. difficile was lower when compared to trusts of similar size and complexity.

- The hospital was visibly clean and patient-led assessments of the care environment (PLACE) scored higher than the national average for cleanliness. Cleaning services were outsourced, but domestic staff were seen to be part of the ward teams.

- During inspection in December 2014, there was an outbreak of Norovirus and appropriate action was taken to control and contain this, through closure of wards and bays. We observed, however, that not all staff were consistently following trust infection control policies in relation to hand hygiene; this was a concern given the outbreak. We brought this to the attention of senior management, and at unannounced inspection in January 2015 we found improved practice.

- Safeguarding processes to protect vulnerable adults, children and young people were embedded.

- Staff had access to a range of mandatory training and attendance was monitored electronically. Mandatory training on end of life care was not yet implemented.

- Most medicines were managed and stored safely, but some medicines were not stored securely in theatres. In ophthalmology, a patient specific direction was developed under a patient group direction and healthcare assistants were administering eye drops. This was not in line with the medicines legislation and best practice guidance.

- Some parts of the building were constructed before current building guidelines for health facilities were available, and this, along with the increased activity at the hospital, resulted in some areas being cramped and outdated; for example, the emergency department, some children's wards and the general intensive care unit (GICU). There were also safety concerns about deficiencies in maintenance, particularly in older parts of the building.

- Most services were well equipped, but there were shortages of some basic equipment across some wards and departments. There were also some delays in the provision of pressure relieving equipment, as the external company which provided them was unable to meet demand. Maintenance and checking of equipment was not undertaken regularly in some areas.

- Interruptions to electrical power on the general intensive care unit interfered with lighting and the continuous functioning of some equipment, such as monitors.

- The siting of a gamma camera outside the confines of the nuclear medicine department created a potential radioactive hazard. Mitigating actions had been put in place, but further action was needed to remove the risks.

- Nursing staffing levels had been reviewed and assessed across the hospital using the Safer Nursing Care Tool. High levels of vacancies were impacting on consistency of staffing to these levels and the National Institute for Health and Care Excellence (NICE) safer staffing guidance. Staffing levels were reviewed on a shift by shift basis and staff moved across wards to try to mitigate risks; however, this led to concerns about lack of continuity and relevant skills to meet the needs of patients of different specialties. This was accentuated by the high number of, particularly medical, outliers (patient not on medical wards) across the hospital due to high demand and insufficient capacity.

- Low staffing levels in diagnostic imaging services, in particular radiographers, was having an impact on safety.

- Medical staffing was at safe levels in most services and there was an innovative model of 'lead consultant for out-of-hours' (work). However, there was not a neuro interventionist in the neuro intensive care unit at night, for patients who need critical care treatment, including respiratory support. There were neuro-intensive fellows in the unit. There was insufficient medical cover, particularly at consultant level, for end of life care services across the hospital.

Summary of findings

- New end of life care plans had been introduced on some selected wards in August 2014, as a pilot. This was in response to the national withdrawal of the Liverpool Care Pathway. Not all wards where the pilot care plan had not been rolled out were aware of the guidance issued. There were concerns that without proper documentation, care provided to patients could be adversely affected.
- The modified early warning score (MEWS) was used effectively to identify deteriorating patients. Some areas, such as the children's wards, needed to improve their use of the early warning score, and clearer systems were needed for the timely referral of patients, whose clinical condition was deteriorating on the wards, to the outreach team.
- Care pathways were being used to standardise care for patients who were acutely ill.

Are services effective?

- In most services care and treatment was provided in line with national best practice guideline, and outcomes for patients were often better than average. The hospital was developing end of life care in line with national guidance. The results of the 2013/14 National Care of the Dying Audit of Hospitals (NCDAH) highlighted a number of areas for improvement. The hospital had since made some progress on the implementation of the action plan.
- The trust had a hospital standardised mortality rate which was higher than expected during April 2013–March 2014. This trust was regularly reviewing hospital deaths within specialities to identify and improve on areas where there might have been suboptimal care. Investigation demonstrated low numbers of potential avoidable deaths. Over a rolling 12 month period (August 2013 to July 2014) the latest data was demonstrating that mortality indicators were within the expected range, although the data required verification. There were, however, some diagnosis groups (acute and unspecific renal failure, pneumonia, cancer of the oesophagus, and cancer of the rectum and anus) that were mortality outliers. The trust was reviewing standards of care for these patients.
- A new initiative of Interim Medical Examiner Group (IMEG) meetings had been introduced to rapidly review all deaths in the trust. The group included representation from bereavement care, pathology, the patient safety team, patient support services and senior clinicians. It was led by the associate medical director for safety. This has improved the quality of information on death certificates and the speed of death certification, information to the Coroner, the communication with families regarding concerns, and the recognition and improvement of patient safety issues, as well as the need to raise awareness about reporting incidents.
- Seven-day services had been developed in medical and surgical services, and most critical care units, but improvement was needed in out of hours consultant cover for the neuro intensive care unit.
- Staff were supported to access training, and there was evidence of appraisal and supervision.
- Staff received relevant training and had the necessary skills and competence to look after patients in their speciality area. However, the need to move nurses to other wards to cover staff shortages, plus the high number of outliers on some wards, meant there was a risk that nursing staff may not have the specific skills and competencies to meet the needs of patients at all times. There were mechanisms in place to support the short term deployment, but some nurses reported they did not feel they always had the appropriate skills to care for patients.
- There was effective multidisciplinary working across the hospital.
- There were a high number of delayed transfers, both internal and external. Discharge planning commenced on admission, but timeliness of discharge needed improvement in some areas.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 to ensure that patients' best interests were protected. There was guidance for staff to follow on the action they should take if they considered that a person lacked mental capacity. However, staff awareness of the requirements of Deprivation of Liberty Safeguards varied. The trust was developing policies to ensure the latest national guidance was being used correctly in all areas, including the emergency department.

Are services caring?

Summary of findings

- Staff were caring and compassionate, and treated patients with dignity and respect. The chaplaincy team were involved in undertaking a specific listening exercise on what compassionate care meant for staff working at the trust. The 10 key recommendations from this report were now being implemented across the organisation.

- We observed outstanding care and compassion in critical care, and in children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care. We also observed examples of outstanding care, such as from reception staff in the emergency department, who, although busy and working under tremendous pressures, made considerable efforts to reassure, inform and direct people presenting to them.

- Patients told us their experiences of care were good. Average response rate of the trust for the Friends and Family Test was above the England average. Between April 2013 to March 2014, 73.6% of patients were 'extremely likely' to recommend the trust to friends and family; this score was, however, below the England average score.

Are services responsive?

- Bed occupancy at the hospital was 92% (January 2013-March 2014), consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. The hospital had been operating at near 100% occupancy (measured at midday) in the months leading up to and during the inspection. Adult critical care was at 89.36% bed occupancy – above the England average of 83.24%. In the months leading up to and during the inspection, bed occupancy in the units was running at between 90% and 100%.

- Despite the best efforts of staff at all levels of the hospital, to monitor and maximise use of available capacity, high demand was having an impact on access and flow throughout the hospital. For example, patients admitted for elective surgery who required planned critical care beds were remaining in theatre recovery areas for lengthy periods of time until critical care beds became available, resulting in admissions to the units during night hours.

- The trust was meeting the national target of 92% of patients to be waiting within 18 weeks, from referral to treatment (incomplete pathway). There was, however, a backlog of patients waiting for surgery and the trust was not meeting the national target for 90% of patients to actually be treated within 18 weeks (admitted pathway). The trust could demonstrate that it was focusing on the longest waiting patients, and those with complex and urgent cases for surgery. Performance against this target was improving; for example, increased theatre use had improved waiting lists in trauma and orthopaedics.

- Emergency admissions impacted on capacity and were adding pressure to services. The lack of available beds was resulting in cancelled operations and patients spending longer times in the theatre recovery areas whilst waiting for a bed. The trust had improved performance over the year, on reducing cancelled operations and patients with cancelled operations being treated within 28 days, but was still not meeting national targets.

- The number of non-clinical cancellations increased at the end of the year when the hospital was experiencing extreme capacity issues and was on 'black alert'. For example, there were 27 non-clinical cancellations for the week ending 10 August 2014; this increased to 55 for the week ending 7 December 2014. Systems were put in place to prioritise operations that should go ahead each day, and to give patients as much notice as possible of cancellations.

- The trust was now meeting the two week cancer waiting time target for referral from a GP to see a specialist. The trust was also meeting the 31 day target from diagnosis to definitive treatment, although this was below the England average for cancer waiting times. The trust was not meeting the target for people to be waiting less than 62 days from referral to start of treatment. There was a detailed cancer recovery plan which included seeking specialist external advice from the NHS Interim Management and Support team.

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- The trust was not meeting the national referral to treatment target time for 95% of patients to be referred and treated within 18 weeks for outpatient services. In some outpatient services, clinic hours were being extended to evenings and also run on a Saturday to improve access. Waiting times for patients upon arrival in the outpatient clinics varied. Some patients could wait several hours to be seen in some clinics and were warned in advance of this possibility.

- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged, but are unable to leave the hospital due to external factors. During our inspection, 200 (16%) medical patients and 54 (6%) surgical patients had a delayed transfer of care. The main cause of delay was the provision of community services, especially care home places, to meet patients' ongoing needs, and timely social care assessment. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.

- The trust was not meeting its own internal targets to review and discharge patients that were medically fit and could go home at set times during the day. Patients were positive about the discharge lounge and this was working well, but this was only used for medical patients.

- The trust steering group was set up to improve discharge arrangements. This included plans to commence discharge on admission, and within 48 hours for patients to have estimated date of discharge and best interest assessment. Patients would be allocated for fast track, simple or complex discharge as soon as possible, and assessment and management would be supported by the trust's integrated discharge bureau working in partnership with commissioners, the local authorities, and the local community and mental health trusts.

- The hospital had a rapid discharge service for end of life patients to a preferred place of care. A recent trust audit (2014) had shown that 47% of patients with cancer, known to the specialist palliative care team, were dying at home.

- We observed mixed sex accommodation breaches on AMU, and the cardiac short stay ward; this compromised privacy and dignity. The staff were reporting when patients needed to be cared for in a mixed sex bay on AMU, but the staff on the cardiac short stay ward did not recognise these breaches. There was also a risk of mixed sex breaches in critical care services, when there were delays to level 1 patient transfers to wards.

- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients living with dementia or those who have a learning disability. We found examples of adjustments made for patients with a learning disability in outpatients and diagnostic imaging, and in surgical services.

- The hospital has implemented an interpreter service. They also encouraged staff with existing foreign language skills to participate in a training programme, enabling them to qualify as an interpreter.

- There were various printed information leaflets available to patients and their relatives across the hospital. All information for patients was only available in English. Patients could request for information in another language, but that request was also only published in English, making it highly unlikely that a patient who spoke another language could access the information in their own language. We did not see any information in an easy-to-read format.

- Departments across the hospital reviewed and acted on complaints, and feedback, to improve services.

Are services well-led?

- Staff were committed to the trust's values of putting the patient at the centre of their work, and were inspired by the CEO's focus on this. They were aware of the trust's vision and had started to be involved in discussions about updating the trust strategy.
- In most services the departmental strategy and vision were recognised by staff. Staff in some departments were not aware or confident that there were clear plans and strategies to address a few significant concerns in a timely way.

Summary of findings

- There were governance systems in place to identify risks and for quality monitoring. But in some services, there was a disconnect between the risks and issues described by staff and those reported to and understood by senior management and the board. These included pressures on service capacity, staffing levels, and the safety of outdated and cramped clinical environments.
- Across services, staff reported a strong supportive leadership from matrons, senior sisters and lead clinicians. They told us the CEO and senior management team communicated effectively with staff at all levels.

- Staff were positive about working at the hospital and would recommend it as a place to work despite the challenges. Across the hospital there was an ethos of openness and transparency, and collaborative multidisciplinary working.
- There was a strong commitment to research in the clinical environment, supported by research nurses.

- Innovative practices were encouraged.

We saw several areas of outstanding practice including:

- The emergency department used a coloured name band scheme for patients, as a direct result of learning from investigating falls in the department. Staff would know, at a glance, which patients had specific requirements, such as a high risk of falls, because of the coloured, highly visible name bands.
- We observed outstanding care and compassion in critical care, and in children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care. We also observed examples of outstanding care, such as from reception staff in the emergency department, who, although busy and working under tremendous pressures, made considerable efforts to reassure, inform and direct people presenting to them.
- A vulnerable adults support team (VAST) was based in the emergency department, and worked across the inpatient and community areas to support and safeguard vulnerable adults from abuse and harm.
- The hospital had developed a specific post for 'lead consultant for out-of-hours' (work). This had led to more effective management of medical patients outside the working hours.
- Consultants involved with elderly patients worked on a locality-based model, and there were named consultants for patients belonging to each GP locality. This had helped to improve continuity of inpatient care, and communication with patients and families, and other healthcare services in the community. Patients found it beneficial because they saw the same consultant every time, and found it was easier to approach consultants should they need any advice.
- A new initiative of Interim Medical Examiner Group (IMEG) meetings had been introduced to rapidly review all deaths in the trust. The group included representation from bereavement care, pathology, the patient safety team, patient support services and senior clinicians. It was led by the associate medical director for safety. This has improved the quality of information on death certificates and the speed of death certification, information to the Coroner, the communication with families regarding concerns, and the recognition and improvement of patient safety issues, as well as the need to raise awareness about reporting incidents.
- The trust used an automated text system to alert staff about vacant shifts that needed to be filled urgently.
- There is a strong ethos of quality improvement and innovation within the neurosurgical department, which includes the development of the first day case intracranial tumour surgery programme within the UK, which has since been adopted by other units nationally.
- The general intensive care unit (GICU) had introduced early mobilisation for ventilated patients and this had resulted in reducing length of stay.
- Guidance and a training package had been developed to support the managing of patients with challenging behaviour in the critical care setting.
- The 'Uncertainty, Safety or Stop' cultural initiative in the neuro intensive care unit (NICU) was credited with giving all staff permission to say 'I do not know how to do this, and I need help'. This had helped to improve patient safety.
- Consultants in the cardiac intensive care unit (CICU) arranged weekend meetings for bereaved families. Families were invited back to the unit to discuss their relative's treatment and death, in order for them to better understand the patient's journey and the reason why they did not survive.

Summary of findings

- Patient profiles were obtained in the NICU to give staff insight into a patient's likes, dislikes and interests. This enabled staff to talk with the patient about subjects that would interest them, whether they were conscious or not.
- The paediatric day care unit included a nurse-led service where nurses had extended roles. These included prescribing medicines and discharging patients.
- To ensure children's voices were heard and acted upon, the day care unit had developed the 'Pants & Tops' initiative. Through this initiative, children were invited to write down on templates what had been 'tops' or 'pants' about their hospital stay. Children who were very young, and were unable to write, could still provide feedback.
- The children and young people's service used play leaders and youth support workers as advocates for children and young people. The service had an ethos of compassionate care and peer support, and social events were actively encouraged for children and for the parents of children with cancer, and long-term or chronic diseases.
- The trust had implemented a 'Ready, Steady, Go' initiative to support young people through the transition from children's to adult services. Young people were involved in deciding when they were transferred.
- The chaplaincy team held a listening exercise with staff to help identify what compassionate care meant for staff working at the trust. The 10 key recommendations from this report were now being implemented across the organisation.
- The bereavement support team were involved in the co-ordination of tissue transplantation. They explained how families could get involved, and supported families through the tissue transplant process. As a result of this service, tissue transplant donation had increased by 300% (from 20 tissue donations in 2011, to 60 donations in 2013/14).
- The Allergy Clinic within the outpatients department, had received a World Health Organization (WHO) award for excellence.

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

Importantly, the hospital must ensure that :

- Nurse staffing is consistently at safe levels, to meet the needs of patients at the time and support safe care.

- Equipment is regularly tested and maintained, and a record of these checks is kept.

- There are suitable environments to promote the safety, privacy and dignity of patients in the cardiac short stay ward, G8 ward and all critical care areas with level 1 patients.

- There is sufficient basic equipment in all departments, and timely provision of pressure relieving equipment, beds and cots.

- The access and flow of patients across the hospital is improved. Discharge is effectively planned and organised, and actions are taken to improve delayed transfer of care discharges.

- All wards have the required skill mix to ensure patients are adequately supported with competent staff.

- No risks are posed to patient safety in the event of electrical failures in critical care areas.

- All risks associated with the cramped environment in critical care areas are clearly identified and timely action is taken to address those risks.

- Overhead hoists in critical units are correctly positioned, and in working order so they can be used, as intended, for patient care.

- There is an effective process embedded into practice for alerting medical staff or the outreach nursing team in the event of patients deteriorating on the general wards.

- There is appropriate management of identified risks in the general intensive care unit.

- There is a definite plan to develop critical care services to meet the local and regional population health needs; this plan to include the provision of appropriate follow-up services.

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- The specialist palliative care team reviews the level of medical consultant support.

- There are safe staffing levels in diagnostic imaging teams to prevent untoward safety incidents occurring.

- Incidents are reported by radiographers, and there is learning from all IR(ME)R and diagnostic imaging incidents, and processes for Duty of Candour are appropriately followed.

In addition the hospital should ensure that:

- All staff follow the trust's infection control policy and procedures, in particular hand hygiene.

- Avoidable pressure ulcers of all grades are reduced across the hospital.
- Medicines are stored securely across the hospital

- Emergency Department staff use evidence-based protocols/care pathways for a fractured neck of femur (a common presenting injury in the elderly) and head injury.
- Patients who are readmitted to the hospital as a 'failed discharge' are effectively dealt with on arrival at the emergency department, and their details are always entered on the hospital system as soon as they arrive.
- The national and paediatric early warning score systems are used appropriately in children's services so that patients who are at risk of deterioration are correctly escalated.
- The requirements of single sex accommodation are met in the acute medical unit and the cardiac short stay ward, and any breaches are monitored and reported, including when level 1 patients remain in critical care settings because of delayed discharges.

- Information leaflets and signs are available in other languages, in plain English and in easy-to-read formats.

- There are robust processes in place to meet the trust's allocated discharge times.

- There are robust arrangements to meet referral to treatment times, but capacity and patient safety within the hospital are adequately assessed, so that areas such as theatres and critical care services are not constantly 'running hot'.

- Patients admitted for elective surgery, who require critical care beds, should not be cared for lengthy periods of time in recovery areas while they are waiting for critical care beds to become available.

- There is a plan to provide compatible equipment across the critical care services, so infusions and monitoring do not have to be temporarily disconnected when patients are transferring between wards and units.

- There is a trust follow-up service for all patients who have been treated on the critical care units.
- Medical staffing in the neuro intensive care unit at night is monitored to ensure the safety of patients who need critical care treatment, including respiratory support.

- There is availability of CT scans out of hours, which does not have an adverse impact on patients being treated in the neuro intensive care unit.

- The multidisciplinary team is involved when planning the development and refurbishment of critical care areas, to ensure the new environment will be suitable to meet the needs of patients.

- Staff are fully engaged with the plans to develop the general intensive care unit.

- There is a suitable environment in the general intensive care unit to ensure safe treatment for bariatric patients.

- An assessment is completed in the general intensive care unit on the impact that the electronic patient records equipment will have on the environment.

- There is an out of hours referral process for critical care beds by the outreach team that results in swift admissions to critical care services, releasing the outreach team to attend to other deteriorating patients in the hospital.

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- The dietician service is available for all patients, rather than just for patients who align to specialist areas of treatment.

- There is dedicated time for staff to attend essential meetings, such as governance meetings.

- The new end of life care strategy is implemented and embedded across the trust.

- Relatives are consulted on the end of life care strategy.

- All staff caring for dying patients undertake mandatory training in end of life care.

- There is continuous support for ward staff to implement end of life care for patients post March 2016, when the end of life facilitators' role comes to an end.

- There is a review of the provision for teenagers, to ensure that there are dedicated facilities to meet their needs in all areas and for all specialties.

- All staff understand the level of safeguarding training required for their role and how this is delivered.

- The trust follows national guidance to test for pregnancy in females before surgery and radiology investigations, in children and young people services.

- All protocols are version-controlled, and include references to information that has been used to inform their development.

- There is a review of the provision of pre admission and assessment clinics for children and young people to help prepare the child and family, and ensure their needs can be safely met.

- The impact of the current environment on services and outcomes for children and young people is regularly reviewed, and immediate steps taken to address any concerns.

- Access to the children's operating department is secure at all times.
- The practice of nurses using patient group directions to produce a patient specific direction in ophthalmology, is reviewed in relation to the medicines legislation.

- The culture and leadership in diagnostic imaging is improved.

- Staff in diagnostic imaging are consulted and updated on improvements, particularly in relation to recruitment of staff and staff rotas.
- The potential radiation hazard, in relation to the positioning of the gamma camera outside the nuclear medicine department, is removed.

- Learning from incidents is shared across all outpatient specialties and all staff groups.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	**Good** ●	The emergency department had procedures in place to support safe, effective, caring and well-led care and treatment, but required improvement in responsiveness. We saw good care and treatment delivered by competent, caring and compassionate staff.

The department had a culture of safety, and incidents were reported and actions were taken in response. The department was visibly clean. Medicines were appropriately managed. Staff needed to improve infection control procedures. The availability of equipment also needed to improve in the department.

The department had appropriate medical staffing levels and, as a major trauma centre, consultants were present 24 hours a day. There were nursing vacancies, but staff were worked flexibly to provide appropriate skill mix and staffing levels, and recruitment was ongoing. The children's department did not always have children's registered nurses, but this was partially mitigated by the specific training competences which had to be in place before a nurse was allowed to work within this department. A number of specialist children's nurses had been recently recruited to start in post over the next few months and this would provide 24 hour specialist nursing for children and young people.

There was a lack of appropriate space for patient care because of regular over-crowding within the main department. The hospital had made significant and innovative efforts to try to improve this by reconfiguring space and attempting to improve the patient flow through the department using a new 'Pit-stop' area within the main entrance to assess patients. This was a new initiative and required time to embed to improve the flow and safety of patients within the department. When the department was busy, appropriate staffing to monitor patients was reported as challenging during peak times. There were effective procedures to assess and streamline

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patients in the department, but the assessment and monitoring of patients whose condition might deteriorate required improvement to decrease risk to patients.

Safeguarding requirements for children, young people and vulnerable adults were well understood, and there were robust checking and follow-up processes and mechanisms in place.

The department provided effective care, delivered to a high standard, although national guidance was not always adhered to. There was an in-house research unit, where innovative care and treatment is considered. Pain relief was offered, and in line with good practice, the effectiveness of this was checked at regular intervals. Multidisciplinary work was clearly evidenced and the department ran its services seven days a week.

Patients gave positive comments about the care they received, and the attitude of staff. Patients were treated with compassion, dignity and respect, and relatives and families were kept informed of on-going plans and approximate time frames. Patients and relatives told us they felt involved in the decision-making process and had been given clear understanding of their situation.

The service had to improve in terms of responsiveness. The hospital was not meeting the national emergency access target for 95% of patients to be admitted, transferred or discharged from A&E within four hours. Patients were, however, assessed and treated within standard times. The department required better translation services and for information to be available in other languages. There was good support for patients with a mental health condition and patients living with dementia, but staff required better understanding to support patients with a learning or physical disability, such as vision or hearing impairment.

The emergency department was well-led by the senior nurses and doctors. The departmental strategy and vision was recognised by staff, and the culture within the department was one of strong, open leadership, mutual trust and respect. Senior staff described the CEO as "inspirational, hands-on

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and patient-focused". Junior staff told us she (the CEO) was regularly seen in the department, even out of hours, and that she talked frequently to patients and relatives, as well as to staff.

Senior medical and nursing staff were proud of their staff and told us "they are our biggest asset". And they provided good, well supervised care. They described "excellent relationships" with South Central Ambulance Service, and with their community partnership in-reach team. There were clear governance procedures to manage risk and quality, although some areas required improvement, such as learning from audits. Staff engagement was good.

Medical care

Good ●

The medical care services required improvement in some aspects of patient safety, such as nursing staffing levels, infection control procedures and availability and/or management of equipment and environment. There was a consistently high number of medical patients cared for on surgical or other non-medical speciality wards where nursing staff did not always feel they had the appropriate skills. The environment was clean. Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm free care.

There were appropriate procedures to provide effective and responsive care. Care was provided in line with national best practice guidelines, and outcomes for patients were often better than average. Staff had appropriate training to ensure they had the necessary skills and competence to look after patients. Patients had access to services seven days a week, and were cared for by a multidisciplinary team working in a co-ordinated way. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

Patients received compassionate care that respected their privacy and dignity. However, we observed mixed sex accommodation breaches on AMU and the cardiac short stay ward. The staff were reporting when patients needed to be cared for in a mixed sex bay on AMU, but the staff on the cardiac short stay ward did not recognise these breaches. Patients told us they felt involved in decision-making about their care.

Summary of findings

Services were developed to meet the needs of the local population. However, the hospital experienced difficulty in meeting the demand for its medical services, and this resulted in long waiting times for admission from A&E. There was specific care for patients living with dementia and mental health conditions. There were arrangements to meet the needs of patients with complex needs, including discharge arrangements. The trust was working with partners to decrease delayed patient discharges, and was also working to improve its internal processes to ensure daily discharge targets could be met.

There were effective governance arrangements, and staff felt supported by division and trust management. The culture within medical services was caring and supportive. Staff were actively engaged and the division supported innovation and learning.

Surgery   **Requires improvement** ●

Surgical services required improvement to support safe care. Medical staffing was appropriate and there was good emergency cover, but there was a shortage of nursing staff, with a high number of vacancies. Agency staff were used, but they did not always have appropriate induction. The skill mix of nursing was not always appropriate for patients, and nursing staff did not always have time to meet patient's care needs. The storage of medicines in theatres required improvement to ensure secure storage facilities to reduce the possibility of misappropriation of medicines.

There was a culture of incident reporting with consistent feedback and learning. The service was taking action to reduce new pressure ulcers, and slips, trips and falls. Infections following fractured neck of femur and following hip replacement were lower than the national average. The environment was visibly clean and staff followed the trust policy on infection control.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period.

Multidisciplinary working was evident. Staff had

access to training, and had received regular supervision and annual appraisal. Consultant-led, seven-day services had been developed and were embedded into the service.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), but some were unaware of the recent changes to DoLS.

Patients told us that staff treated them in a caring way and they were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect. Emotional support for patients with terminal illness was exceptional according to relatives.

Surgical services needed to improve responsiveness. The national time of 18 weeks between referral and surgery was not being met in some specialties, and operations were being cancelled. Services were developing to improve response to increasing demand, and patients had surgery based on clinical need. There were, however, capacity pressures, and a lack of available beds was resulting in patients spending longer times in the theatre recovery areas. There were a high number of delayed transfers of patients ready for discharge, but awaiting a care home or care package. Patients were staying longer than 23 hours on the surgical day unit. There were various inefficiencies in discharge arrangements for surgical patients, with the result that many were discharged later in the day than planned.

There was support for people with a learning disability and reasonable adjustments were made to the service. But information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

Surgical services were well-led. Some staff said they felt pressurised when patient admissions fluctuated, and felt that they received poor support during stressful periods. Strategic plans were addressing capacity issues, and risks were identified, and being managed or were appropriately escalated. There was positive awareness of the values and

Summary of findings

expectations for patient care across the departments. Staff were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.

Critical care **Requires improvement** ●

There were areas of good, outstanding and innovative practice in the critical care services. In the NICU an 'uncertainty, safety or stop' culture had been introduced to give permission for all staff – nursing, medical and allied healthcare professionals – to say, "I do not know how to do this and I need help." Also, band 2 healthcare assistants were completing patient profiles, so staff would be able to talk to the patients about topics they were interested in. In the GICU, the effective use of a research nurse released junior nurses to carry out research projects. A guidance pack for managing patients with challenging behaviours had been developed. Inventive staffing patterns in the CICU had released an extra member of staff to drive discharges and admissions with the aim of improving patient flow through the unit.

However, there were significant risks posed by the infrastructure and environment of the critical care services and staff were not assured that these were being addressed by senior divisional management. In the GICU, the environment was cramped, pillars obstructed the view of some patient bed areas, overhead hoists were not located in fully usable positions, and power failures meant patients were without monitoring equipment for up to 2 minutes while equipment rebooted.

The treatment and care provided followed current evidence-based guidelines. The critical care services participated in national and local audits and there were good outcomes for patients. Staff had effective training, supervision and appraisal and there was good multidisciplinary working to ensure that patients' needs were met.

There were problems with the flow of patients through critical care areas. Patients were discharged to ward areas during the night, which national data and guidance have associated with increased mortality. Patients were remaining in critical care beds when they no longer needed them, which could result in mixed-sex breaches and lack of privacy and dignity. Patients admitted for elective surgery, and

Summary of findings

who needed planned critical care beds, were remaining in theatre recovery areas for lengthy periods of time until critical care beds became available; this resulted in admissions to the units during night hours.

Patients were followed up when they were discharged from intensive care to a ward or their home; however, this was variable depending on the unit in which they had received their care and treatment. Nationally recommended follow-up clinics were not funded and were being done voluntarily by consultant staff.

The leadership teams of individual units were supportive and effective in mitigating risks. Staff reported a strong supportive working environment, which was led by matrons, senior sisters and lead clinicians. There was a vision to refurbish and expand the critical care services, but no agreed plans. Clinical strategies were based on continuing to achieve positive outcomes for patients. Governance processes were focused on risk and quality. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. Critical care staff felt that they were not being listened to, and they were not confident that identified risks to patients were being addressed.

There was strong local leadership in each of the critical care units. There was a culture of mutual support and respect, with staff willing to help other units when they were short staffed. Innovative ideas and approaches to care were encouraged and supported; many of these enhanced patients' experiences in the units

Services for children and young people

Good ●

Children, young people and their families were positive about the care and support they received. They told us they were kept informed and involved in making decisions. The service provided outstanding support to children, their parents and families; peer support and social events were promoted and encouraged for children who attended the hospital often, because of the nature of their illness and particularly in the oncology and neonatal units.

There were systems in place to ensure that children at risk of harm, or considered to be of concern, were

Summary of findings

identified and protected if seen in the hospital. Following a high-profile incident in the past year, safeguarding procedures had been reviewed and new procedures put in place to protect and monitor children who may leave the ward environment. Staff were aware of how to report incidents and this information was monitored and reviewed, and the learning shared. Staffing levels were monitored and openly displayed. Areas were staffed with enough workers with the skills required to care for children and young people. On occasions when staffing levels were not as planned, action was taken to maintain a safe environment.

Children's care was provided based on national guidelines and best practice. Staff were supported in their role, and development opportunities were available and accessible. There was good multidisciplinary team working. A 7-day service was established for medical staff and being developed for all areas including support services such as therapies and diagnostics.

The service was looking for ways to improve access and had extended services, for example, in orthopaedic care and for back pain. There were, however, problems with waiting times for some services (for example, spinal surgery) and children did not always have pre-admission assessment to prepare for surgery. The current environment and facilities needed to improve. There was a lack of bathrooms for children and young people needing extra support (for example, lifting aids), and there were cramped conditions in some ward areas such as Piam Brown. The environmental space had become too small for the services being delivered. This was recognised by the trust and there were plans to start work that would enable the relocation and expansion of two wards. Additional work was dependent on the proposed new children's hospital that was now delayed because of funding problems. The new hospital was planned for 2020 .

Staff worked effectively in teams and were positive about the leadership of the service. The strategy for the service was encompassed in the new hospital. There was no current clinical strategy and plans were being developed to manage service issues as they materialised. There was an established

Summary of findings

governance system to monitor risk and quality . Young people's opinions and input were actively sought through surveys and consultation, and their feedback was used to improve the service.

End of life care

Requires improvement ●

There were procedures to ensure that end of life care was safe and met the needs of patients. Incidents were reported and lessons were being learned, medicines were appropriately managed and equipment for end of life care was available and well maintained. Patients were appropriately monitored and the trust took part in the National Care of the Dying Audit – Hospitals (NCDAH) 2013/14 to identify patients who required end of life care.

The trust was in the process of introducing a new care plan to replace the Liverpool Care Pathway after its national withdrawal in July 2014. The new end of life care plans (called Achieving Priorities of Care) had been piloted on selected wards in August 2014. However, wards without care plans did not have proper documentation and some patients' care needs and risks had not been fully assessed. Some 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not completed in line with national guidance. The trust needed to improve medical staffing levels and ensure that mandatory training on end of life care was available.

The hospital was developing end of life care in line with national guidance. The results of the 2013/14 NCDAH had highlighted a number of areas for improvement. The hospital had since made some progress on the implementation of the action plan but there needed to be more staff education and training around this.

Some 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms we inspected were not completed according to national guidelines. Hospital audits had also identified areas for further improvement, to ensure that forms were signed and verified by a consultant, for discussions with patients and families, and to document mental capacity decisions.

Staff supported patients and their relatives and provided compassionate care. They ensured that patients' privacy and dignity were maintained. Patients received good information regarding their treatment and care. The service took account of

Summary of findings

their individual needs and wishes, and their cultural and spiritual needs. The bereavement support staff provided good support to relatives after the death of a patient. The hospital had a rapid discharge service for discharge to a preferred place of care.

There was pressure on the service in terms of capacity. Some improvements were being made to improve access, for example, the oncology department had opened five new acute oncology beds that could be accessed for end of life care. There was concern, however, about the future commission of the service.

The trust's revised draft strategy for end of life care was recently developed based on national guidance. There was a steering group to monitor performance against national standards and a trust board leadership for end of life care had recently developed. Members of the team that provided end of life care within the trust were passionate and committed to improve the service; staff in the trust wanted to provide good end of life care. The trust had made improvements in engaging with the public and had plans to innovate and improve the service.

| Outpatients and diagnostic imaging | Requires improvement | ● | |

Outpatient staff showed a good understanding about reporting incidents. Learning was shared within specialties but not across the outpatient department as a whole. In diagnostic imaging, there was less consistent reporting of incidents. Incidents under the ionising radiation medical exposure regulation (IR(ME)R) had been reported to the Care Quality Commission. Patients had been told but formal procedures to inform patients under the Duty of Candour had not been followed.

Diagnostic imaging services had been developed to cover 24 hours, 7 days a week working. However, there had been no increase in staffing and radiographers were under pressure to meet the demands of the new rota. This was having an impact on safety with staff working long hours, working alone (which was contrary to policy) and new staff working alongside staff who were also inexperienced. Staff reported that the number of mistakes was increasing.

All safeguarding and mandatory training was up to date, and nurses in outpatient clinics had good

understanding of safeguarding procedures.

Outpatient clinic staff trust-wide showed a very good understanding of assisting patients who had dementia or a learning disability.

In the respiratory centre, the allergy clinic demonstrated outstanding practice and had been given a World Health Organization (WHO) award for excellence.

In ophthalmology and ear, nose and throat (ENT), some extra clinics had been scheduled for Saturday mornings to reduce waiting lists and accommodate patients who could not attend during the week. Patients told us that they felt well cared for and informed about their treatment by compassionate staff, and this care was extended to relatives.

The trust was not meeting the national referral to treatment target time for 95% of patients to be referred and treated within 18 weeks for outpatient services. Waiting times for patients upon arrival in the outpatient clinics varied. Some patients could wait several hours to be seen in some clinics, and were warned in advance of this possibility.

The trust was not meeting the cancer waiting time target for referral to definitive treatment within 62 days

In diagnostics, the trust was performing better than the England average in seeing patients within 6 weeks.

The trust had implemented a new interpreter service to accommodate patients whose first language was not English. However, there did not appear to be any signage or information leaflets available in other languages.

The NHS staff survey 2013 revealed difficulties in relation to the culture and leadership of the service. Mandatory training was up to date for radiographers but there was little opportunity for professional development. Radiographer staffing levels were of concern and having an impact on the safety of the service.

Staff felt supported by their immediate line management, but senior management teams were inaccessible to most staff. This was the case in both outpatient departments and diagnostic imaging.

Summary of findings

A Commissioning for Quality and Innovation (CQUIN) project was initiated to reduce the number of new to follow-up patient appointments and improve performance within outpatient departments

Southampton General Hospital

Detailed findings

Requires improvement 🟠

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; Outpatients and diagnostic imaging

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Detailed findings

Background to Southampton General Hospital

Southampton General Hospital is part of University Hospital Southampton NHS Foundation Trust, which has had foundation trust status since 1 October 2011. The hospital has around 1,300 inpatient beds, has over 150,000 emergency attendances, and sees over 500,000 outpatients each year. Over 8,400 staff are employed at the hospital.

Southampton General Hospital provides a full range of general medical and surgical services to the population of Southampton and South Hampshire. The hospital also provides all major paediatric and adult care specialist services (with the exception of burns, adult renal dialysis and transplantation) to more than three million people living in southern England and the Channel Islands. Specialist services include cardiac services, oncology, neurosciences and paediatric intensive care. The hospital is a designated regional major trauma centre for paediatrics and adults.

We carried out this comprehensive inspection as part of our programme of inspecting and rating acute hospitals. The trust had not been flagged as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. At this location, Southampton General Hospital, we inspected accident and emergency, medical care (including older people's care), surgery, critical care, services for children and young people, end of life care, outpatients and diagnostic services. Most services are provided at the hospital, but outpatient services are also provided at Royal South Hants Hospital.

The trust also provides maternity and gynaecology services at the Princess Anne Hospital, an adjacent location, and hospice services at Countess Mountbatten House. Both were inspected as part of the trust-wide inspection, and findings are detailed in separate location reports.

Our inspection team

Our inspection team was led by:

Chair: Dame Eileen Sills, Chief Nurse, Guy's and St Thomas' NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 60 included CQC inspectors and analysts and a variety of specialists, including: consultant in emergency medicine; consultant gynaecologist and obstetrician; consultant surgeons; consultant anaesthetist; consultant physicians; consultant geriatricians; consultant anaesthetist; consultant radiologist; consultant oncologist; consultant paediatrician; paediatric surgeon; junior doctors; emergency department nurses; midwife; head of maternity and gynaecology; surgical nurses; theatre nurse; medical nurses; paediatric nurses; paediatric physiotherapist; palliative care specialist nurse; critical care nurses; outpatient manager; board level clinicians; governance lead; safeguarding leads; student nurse; and 'experts by experience'.

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?

We carried out an announced inspection visit on 10 and 11 December 2014. We withdrew from the inspection on 11 December, as a precautionary measure, due to an

Detailed findings

outbreak of Norovirus, which resulted in closure of the hospital to visitors. We completed the inspection through unannounced two day inspections to all services between 5 and 15 January 2015.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG); Monitor; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Southampton on 9 December 2014, when people shared their views and experiences of the University Southampton Hospital NHS Foundation Trust.

We conducted focus groups and spoke with a range of staff in the hospital, including nurses, radiographers, junior doctors, consultants, administrative and clerical staff, porters, maintenance, catering, domestics, chaplain, allied healthcare professionals and pharmacists. We also interviewed directorate and service managers and the trust senior management team.

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the outpatients department. We observed how people were being cared for and talked with carers and/or family members, and reviewed personal care or treatment records of patients.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Southampton General Hospital.

Facts and data about Southampton General Hospital

Southampton General Hospital: Key facts and figures

Southampton General Hospital (SGH) is the acute hospital provided by University Hospital Southampton NHS Foundation Trust (UHS), which has had foundation trust status since 1 October 2011.

The hospital provides direct clinical services to over 727,000 patients a year. It provides services to the population (1.9 million) of Southampton and south Hampshire. It also provides specialist services, such as neurosciences and cardiac services to more than 3.7 million people in central southern England and the Channel Islands. The hospital is a regional major trauma centre.

1. Context:

- Southampton General Hospital has around 1,300 beds.
- The local population is around 500,000, of which 100% is urban.
- The number of staff was 8,500 WTE.
- The board has 10% Black and minority ethnic (BME) members representation of executive directors and 6.7% representation of non-executive directors; it has 57.1% female representation of executive directors, and 25% female representation of non-executive directors.

- Deprivation in the city of Southampton is higher than average (79 out of 326 local authorities). The surrounding areas of Eastleigh, Fareham, New Forest and Test Valley are less deprived.
- Life expectancy for both men and women is higher than the England average.
- The annual turnover (total income) for the trust was £645 million in 2013/14.
- The trust surplus was £3 million for 2013/14.

2. Activity:

- Inpatient admissions 140,000 (2012-13)
- Outpatient attendances 520,677 (2012-13)
- A&E attendances 154,260 (2012-13)
- Deaths at SGH 1,947 (April 2013–March 2014)

3. Bed occupancy:

- General and acute: 91.88% (January 2013-March 2015). This was consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Adult critical care was at 89.36% bed occupancy – above the England average of 83.24%.

4. Intelligent Monitoring:

Detailed findings

- The trust had moved from a high priority banding for inspection (band 2), in October 2013, to lower priority banding (band 5) in July and December 2014. Percentage risk score was 6.7% in October 2013 and 3.19% in December 2014, with one elevated risk.

Individual risks/elevated risks:

- Elevated Risk: Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators (1 April 2013 to 31 March 2014)
- Risk: Composite Indicator: In hospital mortality – Trauma and orthopaedic conditions and procedures. (Recurring in last four IM reports, but now a risk – previously elevated risk.)
- Risk: Composite Indicator: Emergency readmissions with an overnight stay following an elective admission (1 November 2012 to 31 October 2013)
- Risk: A&E Survey Q18: 'Were you given enough privacy when being examined or treated?' (1 January 2014 to 31 March 2014)
- Risk: Composite indicator: A&E waiting times more than 4 hours (1 July 2014 to 30 September 2014 and 5 January 2014 to 30 March 2014)
- Risk: GMC – Enhanced monitoring (1 March 2009 to 22 July 2014)
- Risk: The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason (1 January 2014 to 31 March 2014)

5. Safe:

- 'Never events' 2 (April 2013-October 2014)
- Serious Incidents (STEIS) 183 (2013/14) - 42% were pressure ulcers.
- National reporting and learning system (NRLS) July 2013-Dec 2014; no evidence of risk:

Death 13 (0.1%)

Severe Harm 79 (0.6%)

Moderate Harm 364 (2.9%);

Low Harm 3,118 (25.5%);

No Harm 8,650 (70.7%)

Total 12,224

Infection control (March 2013–July 2014)

- 43 cases of C. difficile – no evidence of risk
- 8 cases of MRSA – incidence – no evidence of risk

6. Effective: (December 2014)

- Hospital Standardised Mortality Ratio (HSMR): no evidence of risk (Intelligent Monitoring)
- Summary Hospital-level Mortality Indicator (SHMI): no evidence of risk (Intelligent Monitoring)
- Trauma and orthopaedic conditions and procedures: in hospital mortality indicator: Risk

7. Caring:

- CQC inpatient survey (10 areas): similar to other trusts
- FFT inpatient: above the England average (2013/14)
- FFT A&E : above the England average (2013/14)
- Cancer patient experience survey (34 questions): similar to other trusts for 29 questions; and lowest scoring 20% of trusts for five questions.

8. Responsive:

- A&E four hour standard – not met; below the England average (July 2013–July 2014)
- A&E - time to initial assessment: below England average (January 2013–July 2014)
- A&E - time to treatment: above the England average but, in general, similar to standard time of 60 minutes (January 2013–July 2014)
- Emergency admissions waiting 4–12 hours in A&E from decision to admit to admission: above the England average
- A&E left without being seen: above the England average (January 2013–May 2014)

- 18 week RTT- Surgery - consistently worse than 90% NHS operating standard (July 2013–June 2014)
- 18 week RTT (incomplete) - 92% of patients overall wait for surgery within 18 weeks: met (April to September 2014)
- 18 week RTT (non-admitted, outpatient) - 95% NHS operating standard: not met (July 2013–June 2014)

- Cancelled operations and not treated within 28 days –lower than the England average (April 2011–June 2014) but meeting the target from June 2014.
- Cancer waiting times: meeting standard for urgent two weeks (seen by specialist) and 31 days (diagnosis to treatment) not meeting 62 days treatment (urgent referral to treatment)
- Diagnostic waiting times - six weeks; standard met

9. Well-led:

Detailed findings

- NHS Staff survey (30 questions)Better than expected (in top 20% of trusts) for nine questions; worse than expected for three questions; similar to expected for 18 questions
- Use of bank and agency staff - below the England average
- Sickness rate - below the England average
- GMC National Training Scheme Survey (2013)The trust was within expectation for all areas of the National Training Scheme Survey, except for feedback - this was worse than expected

10. CQC inspection history:

- Two inspections had taken place at the trust since its registration in April 2012.
- Southampton General Hospital was inspected in October 2012 and April 2013. The trust was compliant with standards on the most recent inspections.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	☆ Outstanding	Requires improvement	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostic imaging.

Urgent and emergency services

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

The catchment area of this hospital incorporates a university city with a young population, and a separate population of temporary residents as people leave and arrive into Southampton on the many cruise ships within that district.

The emergency departments at Southampton General Hospital provide a service 24 hours a day, seven days a week to both adults and children. There were three emergency departments providing emergency care and treatment: one was for adults, and the other was for children and young people under the age of 18. These were co-located within the University Hospital site in the city of Southampton.

There was also a dedicated GP referral unit on the AMU (GP AMU); to which GPs can directly refer medical patients for assessment and admission.

The adult emergency department (ED) saw 154,300 patients last year, of which 21% resulted in an admission. This is in line with the English average ED attendances requiring admission. A further 21% of attendees were under the age of 18.

We initially visited the department over two and a half days in December 2014. Because of the Norovirus outbreak whilst we were there, we had to return to the hospital to complete our inspection in January 2015. At that time, we inspected late in the evening and again the following morning.

During our inspections, we spoke with approximately 29 patients and 10 relatives. In the departments, we spoke with a wide range of staff, including nurses, doctors, consultants, senior hospital and operational managers, therapists, support and ancillary staff, and ambulance staff.

We observed care and treatment, and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences.

Prior to and following our inspection, we reviewed documentation from the trust's stakeholders and information provided by the trust. This means that some information, whilst highly relevant, may be three months out of date at the time of the inspection.

Urgent and emergency services

Summary of findings

The emergency department had procedures in place to support safe, effective, caring and well-led care and treatment, but required improvement in responsiveness. We saw good care and treatment delivered by competent, caring and compassionate staff.

The department had a culture of safety, and incidents were reported and actions were taken in response. The department was visibly clean. Medicines were appropriately managed. Staff needed to improve infection control procedures. The availability of equipment also needed to improve in the department

The department had appropriate medical staffing levels and, as a major trauma centre, consultants were present 16 hours a day with an eight hour on call cover for trauma available within 30 minutes. There were nursing vacancies, but staff were worked flexibly to provide appropriate skill mix and staffing levels, and recruitment was ongoing. The children's department did not always have children's registered nurses, but this was partially mitigated by the specific training competences which had to be in place before a nurse was allowed to work within this department. A number of specialist children's nurses had been recently recruited to start in post over the next few months and following their induction period, 24 hour cover would be provided.

There was a lack of appropriate space for patient care because of regular over-crowding within the main department. The hospital had made significant and innovative efforts to try to improve this, by reconfiguring space and attempting to improve the patient flow through the department using a new 'Pit-stop' area within the main entrance to assess patients. This was a new initiative, and required time to embed to improve the flow and safety of patients within the department. When the department was busy, appropriate staffing to monitor patients was reported as challenging at excessive peak times. There were effective procedures to assess and streamline patients in the department, but the assessment and monitoring of patients whose condition might deteriorate required improvement to decrease risk to patients.

Safeguarding requirements for children, young people and vulnerable adults were well understood, and there were robust checking and follow-up processes and mechanisms in place.

The department provided effective care, delivered to a high standard, although national guidance was not always adhered to. There was an in-house research unit, where innovative care and treatment is considered, actively worked with the department. Pain relief was offered, and in line with good practice; the effectiveness of this was checked at regular intervals. Multidisciplinary work was clearly evidenced and the department ran its services seven days a week.

Patients gave positive comments about the care they received, and the attitude of staff. Patients were treated with compassion, dignity and respect, and relatives and families were kept informed of on-going plans and approximate time frames. Patients and relatives told us they felt involved in the decision-making process and had been given clear understanding of their situation.

The service had to improve in terms of responsiveness. The hospital was not meeting the national emergency access target for 95% of patients to be admitted, transferred or discharged from A&E within four hours. Patients were, however, assessed and treated within standard times. The department required better translation services and for information to be available in other languages. There was good support for patients with a mental health condition and patients living with dementia. The emergency department was well-led by the senior nurses and doctors. The departmental strategy and vision was recognised by staff, and the culture within the department was one of strong, open leadership, mutual trust and respect. Senior staff described the CEO as "inspirational, hands-on and patient-focused". Junior staff told us she was regularly seen in the department, even out of hours, and that she talked frequently to patients and relatives, as well as to staff.

Senior medical and nursing staff were proud of their staff and told us "they are our biggest asset". They provided good, well supervised care. They described "excellent relationships" with South Central Ambulance Service, and with their community partnership in-reach team. There were clear governance procedures to

Urgent and emergency services

manage risk and quality, although some areas required improvement, such as learning from audits. Staff engagement was good, but staff commented that senior staff rotated into different positions every 18 months, and whilst this may be seen to be good for individuals, it was viewed as unnecessarily disruptive for team cohesion. However, the trust told us that all members of the teams moved with their Band 7 to further develop their skills under consistent leadership.

Are urgent and emergency services safe?

Good 🟢

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good.

The department had a culture of safety, and incidents were reported and actions were taken in response. The department was visibly clean. Medicines were appropriately managed. Safeguarding requirements for children, young people and vulnerable adults were well understood. Staff needed to complete specific training for child protection, but there were robust checking and follow-up processes and mechanisms in place.

There were effective procedures to assess and streamline patients in the department. During our inspection, the service was under considerable pressure at a time of nationally increased demand for services. This was compounded by a simultaneous outbreak of Norovirus, the Winter vomiting bug. This meant that some wards were temporarily closed to admissions. Due to capacity issues (insufficient bed availability), some patients in the department had to be looked after on trolleys in the corridor. This had the potential to increase the risk to patients if there were insufficient staff to deliver their care or treatment needs quickly. The trust had a nurse and healthcare assistant specifically allocated to this 'queue' for patients to receive the necessary care and treatment, although this staffing did not always match the number of patients in the queue. On our unannounced visit, managers had further mitigated risks by flexing staffing arrangements, so that patients' needs were effectively addressed in a timely manner. When the department was busy, appropriate staffing to monitor patients was a challenge.

The department had appropriate medical staffing levels and, as a major trauma centre, consultants were present 16 hours a day with an 8 hour on call cover for trauma. There were nursing vacancies, but staff were worked flexibly to provide appropriate skill mix and staffing levels, and recruitment was ongoing. The children's department did not always have children's registered nurses on all shifts; adult nurses had specific training to work within the

children's department. A number of specialist children's nurses had recently been recruited to start in post over the next few month and following their induction period 24 hour cover would be provided.

Staff needed to improve infection control procedures and the availability of equipment also needed to improve in the department.

Incidents

- Reporting of incidents was encouraged by senior staff.
- There was one serious incident (SI) requiring investigation during the previous year. The most common themes for incident reporting related to pressure ulcers seen on patients coming into the department (which were not caused by the department), and capacity and overcrowding issues.
- Incidents were reported using an electronic system. All staff we spoke with were familiar with this, and were able to use the system with competence. However, some staff we spoke with said they found the 'grading' of incidents to be inconsistent, depending upon the person who was reporting them.
- All nursing and medical staff we spoke with were able to describe changes made to processes or practice as a direct result of 'learning from incidents'.
- The incidence of falls has recently risen in the department. A senior member of nursing staff explained this rise by stating there were recently far higher numbers of frail elderly attendees in the department.
- Lessons were learned and improvements made after a root cause analysis of falls. For example, patients were given coloured name bands to quickly identify those who may require more assistance or those who may be at risk of falling, and a senior clinical review now occurred for chest X-rays prior to discharge, to guard against overlooked aortic aneurysm.
- Morbidity and mortality meetings were held within the trust and were attended by ED senior staff.

Duty of Candour.

- Senior staff we spoke with were aware of the Duty of Candour legislation and were able to describe the responsibilities required. They could outline the various stages of response, including the requirement for a written record when meeting with patients.

- Staff in the ED were less aware of the Duty of Candour, as they had not all attended the latest guidance or training, but they were clear about a culture of openness and transparency.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. The thermometer applies to inpatient wards and not the emergency department. However, the clinical decision unit is included.
- The clinical decision unit had a low prevalence of pressure ulcers but a high prevalence for falls. Between January 2013 to November 2014 there had been 23 falls, the prevalence rate was 12.8%. This data reflected both patients admitted having sustained a fall and those who fell in the CDU, so could be misleading. The reported number of in-hospital high harm falls for CDU for this period was four and all went through a detailed root cause analysis. In addition, ED had implemented a new risk management approach to minimising falls by assessing on attendance and making use of a wrist band to identify patients at high risk of falls. This has generally reduced the number of falls in ED and was in place at the time of inspection.
- The emergency department used a coloured name band scheme for patients, as a direct result of learning from investigating falls in the department. Staff would know, at a glance, which patients had specific requirements, such as a high risk of falls, because of the coloured, highly visible name bands.

Cleanliness, infection control and hygiene

- The department was visibly clean, and there was a regular cleaning schedule in place.
- Equipment and surfaces which had been cleaned had stickers attached to indicate their readiness for use.
- All cubicles had a 'ready to use' sign off sheet indicating areas which had been cleaned. These were dated and signed appropriately.
- During our announced inspection, staff did not always adhere to common infection control practices, and did not always wear personal protection equipment (PPE), such as gloves and aprons, when attending to patients. The hospital had an outbreak of Norovirus at this time

and infection control standards should have been higher than usual. We asked if the department was short of supplies, but they were not. When we returned on our unannounced inspection, we observed good infection control practices, and PPE was worn as required.

- Staff complied with the 'bare below the elbows' policy in clinical areas, and washed their hands and/or used hand gel between each patient. Minimal jewellery was worn, in line with trust policies.

- There were 'Hand Hygiene Technique' wall-charts in place to remind staff and visitors about the correct technique. One relative said this was informative, and she had changed her hand-washing practice as a result. Hand hygiene audits were undertaken.

Environment and equipment

- The environment was small and cramped, so overcrowding was a persistent issue. On our announced visit, we noted that patients on trolleys in the corridor had no access to curtains or call-bells, and this potentially compromised their safety in terms of appropriate observations, and monitoring, privacy and dignity. A circulating nurse and healthcare assistant were allocated to look after people in this trolley queue. A spare cubicle was used when patients required personal care or repeat treatments, such as electrocardiograms (ECGs), to be done. Though not ideal, patients were moved from the queue for care and treatment, and then moved back to their trolley space until a more appropriate area became available.

- There was a room specifically for people with mental health issues in which to be seen; it was furnished with appropriate furniture.

- The space dividers in resuscitation were wooden and damaged.

- Cubicles and work areas were generally well-resourced with appropriate equipment; we noted that majors cubicles had no shelving, and thus limited storage capacity for disposables such as vomit bowls and tissues. However, this did not impact on the delivery of care we saw, as these were taken to the cubicle when personal care was carried out.

- There were two clinical decision units, and these were used as single sex bays.

- Staff told us that retention of equipment, such as electronic pumps, could be a challenge, as they were transferred to the wards with patients, and not always

returned as soon as they could be. However, to mitigate this, there were reminders on the 'Continuous Improvement' board to remind staff to bring these back to the unit where they belonged.

- Small but necessary items, such as electric leads for pumps, were not always as accessible as staff required. They told us "they just disappear, no matter how we try to track them". Senior nursing staff were aware of this, and reminded staff to ensure all electronic equipment needing to be charged was appropriately plugged in between patient treatments.

- Three new ECG machines had been ordered for the 'Pit stop' assessment area, and they had arrived on the unit before our inspection.

- Security guards constantly walked around the department; they were a highly visible presence and this provided a safeguard deterrent to the location property, staff and environment.

- Patients who were temporarily on trolleys in the corridor did not have access to electronic buzzers: they were, however, monitored by a circulating nurse and healthcare assistant.

- Resuscitation equipment was checked daily, and cleaned and re-stocked after any equipment use.

- As a major trauma centre, staff had access to specialist equipment, such as rapid transfusion equipment and major haemorrhage packs.

Medicines

- On our announced visit, we had some concerns regarding the safe storage of some medicines, which were found in a locked cupboard but not in their original packing. The issue was raised with the service and on our subsequent unannounced visit this practice had stopped.

- Medication charts were clear and signed, and medications were listed with correct pharmaceutical names, times, frequency and routes of administration. In a few cases we saw that start and completion dates had not always been inserted.

- We observed that FP10 prescription pads were stored in a locked office not a secure cupboard. We advised the department of this, and on our return visit, these were stored in accordance with guidance.

Urgent and emergency services

- A noticeboard poster celebrated '100% compliance with CD (Controlled Drug) book documentation'. This indicated that the correct checking procedures were in place, and that the stock levels of controlled drugs were constantly reviewed in accordance with good practice.

Records

- Patient records were written and electronic.
- Care and treatment checklists were mainly completed, and were signed.
- Urine output was not always recorded within the notes or fluid balance charts.
- Risk assessments for the risk of falls and pressure ulcers, particularly in elderly people, were completed consistently.
- Safeguarding checklists for children, young people and adults were securely in place.

Safeguarding

- There was a safeguarding policy and procedure in place; it was well understood within both the adult and children's departments.
- Receptionists knew to check on the relevant systems and lists held by other local bodies. They said this was done for all children and young people attending the department. Cross checks were made with both name and date of birth to ensure accuracy. Both paper and electronic checking systems were in place, and reception staff spoke to nursing staff if they had a query, or to alert them to the presence of a specific child in the department. They were aware of escalation procedures, and who they would speak with.
- The trust had reassessed staff that required level 3 training, and the ED was finding it difficult for staff to attend this training. Trust-wide compliance was 38% in August 2014. Face-to-face training was the preference, as this was seen as more robust, but the child protection team did not have the resources to deliver bespoke packages of training to departments. E-learning had recently been developed for level 3 training, but figures were still lower than required, as the training would still take six to seven hours to complete. This was on the risk register and actions were being taken to mitigate risks; the level of child protection awareness training was 68% trust-wide and level 2 training was increasing.
- Nursing and medical staff were clear about their responsibilities and had received appropriate

face-to-face training. A member of the medical staff told us they had recently undertaken level 3, although it had taken "a while" to get a place on this course. We were told by domestic staff that they did not receive any safeguarding training although they worked within the departments. However, their general level of understanding was high and when asked, they said they would refer any worries or queries to the nursing staff immediately. The trust confirmed to us that all staff receive safeguarding training during induction. Vulnerable adults awareness was also high and there was a specialist team (the vulnerable adults support team, VAST) working between the department and the local community. Staff from this team covered the hours 2pm to 10pm, with some 8am-4pm cover. There was no permanent funding for this team and the service would be evaluated at the end of March 2015. There was a high level of awareness of issues of domestic violence and how this could impact on the extended family. There was targeted training to ensure staff were aware of alcohol referrals. This training was not trust-wide, but staff were enabled to attend if necessary for their role.

- The VAST was led by a consultant nurse and there was a support worker and project worker. The team saw patients with alcohol and substance misuse, homelessness, domestic abuse and mental health/self-harm problems. Their focus was on clinical priorities and psychosocial interventions and this supported the release of nursing and medical staff to clinical priorities. There was liaison with community services and signposting patients to support services. For example, the service had liaised with housing, for people who were street homeless or at risk of homelessness; and community services and the police for people suffering domestic abuse. New guidance on refusal to treat, manage self discharge and absconding had reduced the number of missing persons from 44 in 2013 to 22 in 2014.
- Risk assessment tools and audits were used to translate evidence-based practice into working guidelines. An example of this was where the ED staff linked with the gynaecology staff to comply with the mandatory reporting of female genital mutilation.

Mandatory training

Urgent and emergency services

- The trust submitted data about the mandatory training of their staff. This indicated that records were kept of attendances and that appropriate training opportunities were in place.
- The department had an induction programme attended by all new clinical employees.
- Nursing and medical staff had undertaken specialist training in intermediate or advanced life support.
- Emergency department staff had undertaken level 2 Child Protection training.
- Level 3 training was available to senior medical staff, although they had not all attended it yet.

Assessing and responding to patient risk

- Data showed that the trust perform better than the national average with an immediate initial assessment, compared to the England average of three minutes, and the national standard of 15 minutes. The trust time to treatment was similar to the standard time of one hour, but above the England average of approximate 50 minutes (January 2013 to April 2014).
- Emergency call handovers used the established 'ATMIST' format; this ensured that the age/time/mechanism/ injury/signs and treatment information was immediately available to the receiving clinical staff. ATMIST forms were adhesive and stuck into patients notes on arrival, so that this important receiving information was immediately accessible.
- Patients arriving by ambulance were halted at the 'Pit stop'. The Pit stop area was developed because of regular over-crowding within the main department, and this aimed to reconfigure spaces, and assess and streamline patients for treatment. This was an assessment area inside the ambulance entrance. It was staffed by a qualified nurse. Immediate assessment, observations and initial tests were carried out, so that these results would be quickly available to the attending doctor.
- Infants less than two months old were seen immediately, and children less than three years old had to be discussed with the duty children's registrar or consultant.
- Anyone presenting to reception with acute onset of chest pain was immediately led through to the assessment area to be seen by a clinician.
- People presenting on foot via the reception area were initially assessed (triaged) by a trained nurse with these competencies.

- Specific guidelines for the correct streaming of presenting patients were in place. This ensured that people were quickly assessed and sent to the correct area to address their care and treatment requirements.
- National early warning scores (NEWS) were not consistently in place, and staff told us this was because the scores were not validated for use in the emergency department. A modified medical early warning score (MEWS) was in place to identify the deteriorating adult patient, until the national validation process has been completed.
- Where abnormal vital signs were noted, this was reported to the nurse in charge, and the timed recordings of these increased in line with the degree of severity.
- It had been identified that there was the potential for some patients to receive sub-optimal care. The Pit stop had only started in the last six weeks and was described as "a work in progress", as the process for dealing with deteriorating patients was not fully embedded. Assessment scores were not always totalled; this made the immediate recognition of a deteriorating patient harder to track, particularly in a corridor in a busy department.
- Paediatric early warning scores (PEWS) were started in the children's emergency department, for use on the wards.
- Patients were moved in and out of the resuscitation bay dependent upon clinical need and priority.
- The pressures in the ED meant that patients were temporarily cared for on trolleys in corridors. Patients on trolleys in the corridor had their risks assessed by initial assessment and recording of vital signs. A circulating nurse and a healthcare assistant were available to re-assess and provide care and treatment. However, the numbers of patients on trolleys was highly variable and unable to be predicted. The staffing of the department during our reflected the team's approach to flexible staffing to ensure that patients were observed appropriately; but this was a challenge at times, with more patients on trolleys in the corridor than nursing numbers could accommodate.
- When queues continued to build, physical access to patients on trolleys in the corridor became increasingly difficult. There were escalation plans, and patient times of 'queuing' in corridors were monitored via their notes and on electronic departmental records. There was

active management to transfer patients to more appropriate areas as soon as they became available, and patients were moved based on clinical need rather than on queuing time.

- One elderly gentleman was identified as a 'failed discharge'. This meant that he returned to the hospital after being discharged from a ward. His details were not entered onto the IT system when he returned to the department, as it was thought he would immediately transfer back to the ward. He was nursed on a trolley in the corridor by the Pit stop team, but his needs were not fully assessed or monitored. It had been assumed that he was on the IT system.

Nursing staffing

- A staffing needs assessment tool was used to clarify and define how many staff, and whether qualified or unqualified, were required on each shift. The staffing requirement for each shift was clearly identified on the unit, and any shortfall was also noted.
- Nurse staffing was well-planned and resourced. The total nursing staff was 168 whole time equivalents. At the beginning of 2014, there had been a 19% vacancy rate, but at the time of our inspection, the vacancy rate was 7.9% (below the national average of 9%), and recruitment was still ongoing. There were five new nursing staff due to start in January 2015 as part of a planned strategy.
- Nurse staffing was monitored by the matron and senior shift leads, and national recommendations for staff working within the resuscitation room were adhered to.
- There was not always a minimum of one registered children's nurse on each shift, as identified by national guidance. However, registered adult nurses had undertaken specific competences to enable them to run the children's ED in a safe manner. A number of specialist children's nurses had been recently recruited to start in post over the next few months and following their induction period would be counted in the nurse staffing numbers.
- There was an overall lead for children's care in the department.
- Nursing numbers and skill-sets were appropriate to the needs of the patients, and these were flexed as necessary to meet the ever-changing needs of patients.
- A senior member of staff told us that the overnight nurse staffing in the clinical decisions unit (CDU) was

sometimes too low. They described a situation where one nurse could be looking after seven or eight confused elderly patients. This, however, was not evident from the rotas or our observation.

- Handover meetings took place at the beginning and end of each shift. We observed that a comprehensive relay of information about patients, problems, staffing and any arising matters, such as people expected by ambulance, was delivered to the incoming staff. In this way, the flow of relevant information required to run the shift was up to date. Information about departmental responses and performance was also relayed at this point.

Medical staffing

- There was a higher than average number of consultants employed within the departments. The England average was 23%, and the trust had 30%.
- The total medical staffing number was 51 whole time equivalents, of which 30% were consultants, 8% middle career grade, 44% specialist registrars and 18% junior staff at foundation year 1-2.
- As the department is a major trauma centre, consultant presence was in place 16 hours a day with an 8 hour on call cover for trauma. Consultant staffing rotas were recently changed to better match patient throughput.
- There was a minimum of one registrar working towards consultancy status in the department 24/7.
- Handovers were written and verbal, and took place at the beginning of each shift change. The nurse in charge did not attend these, although this is currently being looked as a potential change in practice.
- Medical staff looking after children were appropriately trained in advanced paediatric life support.

Major incident awareness and training

- The trust had identified as a moderate risk that they may be non-compliant with statutory duties under the Civil Contingencies Act 2004, and NHS England guidance 2013 for emergency preparedness, response and resilience. In response, the trust had updated its major incident plan, and implemented staff training. There was an improvement plan for the electronic patient record recordings, but action taken had not been assessed.
- The trust had a major incident policy and procedures, and these were known to departmental staff, senior managers and trust operational managers.

Urgent and emergency services

- Major incident awareness was high amongst all nursing and medical staff we spoke with. We asked for and were provided with evidence that they had received appropriate training. They were able to confidently describe the actions they would take in particular scenarios, such as a major road traffic accident with multiple casualties, chemical and biological hazard presentation, and radiation leaks.
- The trust had a major incident plan which had been recently reviewed, set out roles and responsibilities, and indicated where specific equipment and specialist clothing may be obtained. Major incident resources were instantly available and these included necessary equipment, such as biohazard suits and tenting.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good ●

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

National guidelines and best practice were being used to provide evidence-based care and treatment, although some care pathways were not followed. Patient outcomes and results of national audits were within expected ranges. Pain relief was offered appropriately in most cases, and its effectiveness was assessed and acted upon. Patients were offered food and drink, and these were documented on nursing notes.

Staff were competent and had undertaken appropriate specialist training for the environment in which they worked. Multidisciplinary working was in evidence to centre care around the patient. There were regular discussions with professional staff, both within the hospital location and the local community. Staff had a good understanding of consent and the Mental Capacity Act, but Deprivation of Liberty Safeguards (DoLS), in the context of an emergency department, was not well understood. The trust was updating its guidance for staff in this area.

Evidence-based care and treatment

- The departments used a validated triage tool (the Manchester Triage Assessment) to ensure patients were directed to the most appropriate care and treatment areas, such as minor injuries, major treatment, or resuscitation departments.
- National Institute for Health and Care Excellence (NICE) guidelines were used, but not for all practice; for example, they were adopted for specific care pathways such as shortness of breath, but not for a fractured neck of femur (a common presenting injury in the elderly), or for head injury. Local updated guidelines were also used.
- Paediatric (children's) NICE guidelines used, such as for head injury and fever, were the most recently available. There were also new guidelines for trauma and female genital mutilation.
- The department had a substantial research programme; this was nurse-led, and the department was engaged in regional and national networks.
- The university research group displayed information about its ongoing trials within the resuscitation area; this ensured that people presenting with specific injuries or conditions of interest to the research team had the facility to be seen and recruited onto new trials by experts within these fields.

Pain relief

- Nursing records demonstrated patient's pain was assessed and scored, and there was regular assessment of further interventions.
- Patient group directions were in place for the administration of pain reliving medicines by nursing staff. Patients presenting with acute pain were quickly assessed and analgesia administered. We observed pain relief being offered to patients requiring it, and patients being asked later if it was effective.
- Two members of the public noted that in the minors area waiting room there is a poster stating 'if you need analgesia please ask', but that they did not know what the word analgesia meant. It is possible that people requiring pain relief did not ask for it if they did not understand the wording on this information poster.
- Most people we spoke with, who had required pain relief medication, told us they had been given appropriate medication.

- One young person requiring pain relief did not have this when required. This had not been done within a substantial period of time, and we alerted the staff to this. They took immediate action, administered pain relief after assessment, and commenced an internal review to see how this could have happened.

Nutrition and hydration

- People in the majors department told us they had been offered food and drink.
- Families confirmed that if their relative was in the department for more than a few hours, they would usually provide food for them. Staff confirmed they discussed with families if their relative had any restrictions on eating and drinking whilst in the department.
- Where necessary, patients had intravenous fluids for optimal hydration. The fluid intake of patients was appropriately completed on fluid balance charts to ensure an accurate assessment could be made of their continuing requirements. However, fluid balance charts we checked did not always have urine or other outputs logged on them, which meant the patient's presenting balance of fluid was not always accurate.

Patient outcomes

- The departments took part in national audit schemes, such as infection control and the quality of radiographs (X-rays).
- The departments performed well in the 2013-14 College of Emergency Medicine (CEM) Vital Signs audit for measuring vital signs and repeating these observations during the visit, although the standard for initial assessment within 20 minutes was not met. Observation charts we checked showed that these were consistently filled in at appropriate times. The CEM consultant sign-off requirement was not always completed: this meant that high-risk patients had not always had their notes reviewed by a consultant before they left the department.
- The CEM severe sepsis and septic shock audit was within the guidelines, although the initiation of high flow oxygen was not always recorded within notes.
- · Appropriate investigations were carried out and the results were noted in the patient record before their

discharge from the department. Consultant review took place before specific attendees were allowed to leave the department, such as anyone who had presented with chest pain.

- Antibiotics, where required, were administered before the patient transferred out of the department.
- The unplanned re-attendance to ED within seven days was consistently above the England average. Patients said it was "impossible" to get a GP appointment in less than three weeks and so they attended ED instead.
- The department had a significantly higher number of attendees requiring admission during 2013-14. Although the department is in line with the England average for attendee admission rates (21%), this was significantly higher than the previous year (15%) in 2012-13. Senior staff told us they noted that elderly attendees had increasing needs due to multiple co-morbidities. This was said to result not only in admission, but in an extended stay in hospital. One member of staff described attendees as "they are older, sicker, and have far more, and more complex needs than ever before. They require substantial care in the department before being transferred to a ward".

Competent staff

- There were extensive staff development programmes available, providing specialist education and skills training to further develop staff skills and competence. This was accessed via the university education department and in-house education team.
- The knowledge and skills base across all bands of nursing and medical staff was appropriate to the departmental and patient requirements. These skills, such as advanced life support, were well-documented on a training grid and within staff records.
- Staff told us they were "heavily encouraged" to develop their knowledge and practice. However, one member of staff said that Wednesdays were "supposed to be education days but are often cancelled due to staffing".
- Nursing and medical staff described the education available to them as "excellent, first class". They had access to a wide range of in-house and external development opportunities
- Supervision took place at regular intervals between junior staff and their mentors. This gave the opportunity for individual staff performance to be identified and managed.

Urgent and emergency services

- Appraisals took place annually, and were evidenced with clear parameters set, and goals achieved. Information submitted by the trust indicated this had taken place for 73% of nursing staff and 100% of administration staff in the emergency department.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within emergency medicine rated their overall satisfaction with training as similar to other trusts. Workload, however, was an outlier that was below the national average.

Multidisciplinary working

- The matron, consultants and senior managers praised the effective working relationships between the many disciplines in the hospital and the local community. They described excellent functional relationships with all major interdependent clinical specialties, such as medicine, surgery, paediatrics and critical care.
- The senior management team praised the work of the operational, bed management and clinical site management staff who met to plan strategy for bed capacity. They said "it is such a difficult task, but they really try to work through the issues".
- ·We attended bed management meetings and daily strategy meetings, and noted the teamwork and good functional relationships within these meetings. The hospital was working under considerable pressure due to the current national capacity issues, and also due to an outbreak of Norovirus, which impacted severely upon their bed capacity. There was a good understanding of the patients' individual care and treatment requirements, and where these could best be met. This led to co-operative discussions between the departments attending the meetings.
- 'Huddle' meetings took place three times a day within Division B: these were attended by senior clinical and operational staff, and the intention was to have a comprehensive overview of 'live' ED performance, reviewing bed state, care group beds available, outlier patients, staffing for the day, and priorities for the day. A huddle later in the day looked at discharges achieved, repatriations to other trusts, and a review of the number of the patients in ED awaiting admission into the acute medical unit.
- Nursing and medical staff working in the department told us they had good relationships with many professional groups, including occupational therapists,

pharmacists, physiotherapists and discharge teams. They said they worked together well to ensure patient outcomes were "as good as they could be, as quickly as possible".

Seven-day services

- Consultant staff, including paediatric staff, were available seven days a week, over a 24 hour rota, comprising of 16 hour on-site presence until midnight and eight hour on-call cover
- Staff had access to the specialist skills of therapy staff such as physiotherapists and pharmacists; they worked seven days a week, and an on-call team was available out of hours.
- The community psychiatric liaison team was available over a 24 hour rota to give specialist advice or to undertake assessment visits in the department.

Access to information

- Staff had access to electronic patient records, and this enabled them to view previous inpatient and outpatient attendances, care and treatment given, and plans in place. This ensured duplication did not occur, and up-to-date information was available.
- When people moved between different services, the referral information was available at the point of patient transfer. This was verbal, written and electronic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in the department did not have a thorough understanding of the Deprivation of Liberty Safeguards (DoLS), although the Mental Capacity Act 2005 was well understood and put into everyday practice. Some staff were aware that if DoLS were in place for a person presenting to the department, then there were specific requirements that must be adhered to for that individual.
- There was a comprehensive Mental Capacity Act and DoLS assessment algorithm dated November 2014. There was also a DoLS assessment proforma, and this included referral procedure details for different age groups, and for working hours and 'out of hours'. The trust was updating its guidance on DoLS in an emergency department to reflect new national guidance.

Urgent and emergency services

- Informed consent was actively sought before any care or treatment was carried out. This was recorded in the patient's notes.
- People were enabled to make appropriate decisions by clear explanations of care and treatment to be provided, timelines and expected outcomes.
- Where people lacked the mental capacity to make a decision at this point in their care, staff made 'best interest' decisions and recorded these in clinical records.
- The department had a clear restraint policy in place.

Are urgent and emergency services caring?

Good ●

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Staff provided compassionate care and ensured that patients were treated with dignity and respect despite the challenges of the service demands and the environment of the unit. The receptionist staff in the ED provided outstanding care and support to people.

There were positive comments from patients about the care received, and the attitude of motivated and engaged staff. Patients and their relatives and families were kept informed of on-going plans and treatment. They told us they felt involved in the decision-making process and had been given clear understanding of their situation.

The results of the NHS Friends and Family Test (FFT) were higher than the national average, and the trust scored similar to other trusts for the CQC inpatient survey, which included questions about privacy and dignity in A&E and access to information. In the 2014 A&E survey, the trust was similar to other trusts, but was worse for questions around safeguarding patients and waiting times in the A&E department. Emotional support was being provided by staff for patients and their families, although when the department was busy, the welfare of patients was not always immediately addressed.

Compassionate care

- We observed the reception staff in the ED demonstrating outstanding social interactions. The receptionists, although busy, made considerable efforts to reassure, inform and direct people presenting to them. This practice was evident on each shift, including the night shift. This should specifically be seen in the context of an exceptionally busy department working under extraordinary pressure because of the Norovirus in the hospital and the national capacity pressures on the NHS at that time.
- There was a high volume of comments from patients and their relatives praising the care delivered by all staff. There were comments regarding the ancillary staff, such as porters and cleaners; these were praised and singled out for taking the time to say hello and pass the time of day when they were working in the department.
- Care was delivered with appropriate instructions and checking of understanding. Most staff took time to listen to people's concerns and were observed to act in a respectful, considerate and supportive manner.
- We observed one elderly patient lying on a trolley in the Pit stop area: he was awaiting a bed, but had been placed in a draughty corridor, and had remained there for two hours. His privacy and dignity were cared for with transfer to another room for care episodes when necessary.
- However, during the night shift we noted a distressed elderly lady in the majors area; her concerns were not addressed by the healthcare assistant looking after her. Whilst she was given care and observation for her physical needs, her psychological distress was not completely addressed and this continued over some time. We addressed this with a member of the nursing staff, who promptly intervened and ensured her distress was alleviated.
- The results of the NHS Friends and Family Test scores were consistently higher than the national average from 1 April 2013 to 31 July 2014.

· The ED scored similar to other trusts for the CQC inpatient survey 2014, which asked questions about privacy, dignity and access to information in the emergency department.

- In the 2014 A&E survey, the trust was similar to other trusts, but was worse for questions around safeguarding (if they felt threatened by other patients) and access and flow (how long they waited) in the A&E department.

Urgent and emergency services

Understanding and involvement of patients and those close to them

- Most relatives told us that they were kept informed of all care and treatment to be carried out. Medical staff were praised for the quality of the communications to the families, in ensuring the patient and family understood the sequence of events, and the likely timings around these.
- One family told us of their initial concern when their family member was on a trolley in the corridor. They then said they were reassured to see a circulating nurse and healthcare assistant checking on these patients, ensuring they had the care and treatment they required. They understood the necessity for a trolley, and had been informed of the reasons for the delay in a bed being available.

Emotional support

- We saw one family being supported whilst their relative was being treated and cared for in the resuscitation area. They were given clear information and their understanding was checked. They were given the opportunity to talk within a private area.
- We heard the reception staff respond to an anxious family; this was done in a calm and reassuring manner, and the receptionist promised to obtain more detail and pass it onto the family. When we asked later, this had been done.
- There were chaplaincy services available for those who may require them for psychological and emotional support through periods of emotional distress.

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

Requires improvement ●

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as requires improvement.

The emergency services were developing strategies to assess and streamline patients more effectively and improve the responsiveness of the service. The service demand was high, and the flow of patients was sometimes blocked by internal capacity issues in the hospital, resulting in patients waiting on trolleys in the corridors. The trust had not met the national four hour emergency access target for 95% of patients in the A&E department over the past 12 months, and the national pressures on the NHS during December 2014 had exacerbated the problem.

The department was not meeting some people's individual needs. The department had good information about what happens within an emergency department, but was not well signposted. Translation facilities were available, but were not used within the departments. Information leaflets were only printed in English. There was a clear understanding of the requirements of people living with dementia, and relatives were always able to stay with them whilst in the departments. Staff, however, were not always able to inform us or demonstrate knowledge of specific provision for people with learning disability, or with vision or hearing impairment.

The trust was assessing and treating patients within standard times, and ambulance handover times demonstrated minimal delays over 30 minutes. Patients were being appropriately admitted to hospital based on their clinical needs and not by their length of stay in the department. There was a community team in the ED to facilitate discharge planning.

Complaints were handled appropriately and lessons were learnt for improvement. Complaints in the children's department used a whiteboard, where children could describe what was 'pants' or 'tops' about their care and treatment. This was innovative for some children, but the information was not permanent and kept for monitoring, and young people said it was 'babyish' and would therefore not consider commenting.

Service planning and delivery to meet the needs of local people

- The ED was divided into two distinct areas, one for the provision of care and treatment to adults, and the other for care to children and young adults under the age of 18. These were co-located within one building with a single point of access front door. The children's area had a separate waiting room with toys and appropriate seating.
- There was a 10 bedded majors area, two separate resuscitation areas both with the same capabilities and

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a minors cubicle area with its own waiting area. There was a quiet room for the comfort of patients presenting with mental health issues, and a small receiving room for relatives who may require private conversation.

- Two clinical decision units provided accommodation for those patients awaiting further treatment decisions to be made; these were used as single sex areas.

- The main ED contained an area called the 'Pit stop'. The Pit stop was introduced as a new quality service improvement to assess patients arriving by ambulance. The service was led on a shift basis by a nurses of band 6 or above, to undertake the initial observation and assessment of patients and streamline patients for medical assessment. The service was described as "a work in progress", as it had only been in place for six weeks when we inspected.

- Capacity issues meant that sometimes patients waited in areas not originally intended for assessment or care and treatment (corridors). Staff understood the difficulties inherent in using non-clinical environments for patients with clinical needs, and were ensuring patients were moved as soon as possible to more appropriate areas dependent upon their clinical needs.

- Emergency plans and 'Winter plans' were available and in use, requiring regular conversations with local trusts regarding the repatriation of their patients to ensure the capacity and flow at Southampton remained as fluid as possible.

- Inadequate capacity within the ED to maintain the assessment of mental health and self-harm patients had been identified as a risk. There was also no capacity to deliver care packages for frequent attenders within ED. The trust liaised with the local NHS mental health services to improve liaison with psychiatry services, and access for people with a learning disability and mental health disorders. The service was on site, and a second consultant psychiatrist was employed by Southern Health NHS Foundation Trust to assess patients who were diagnosed with mental health disorders. The funding for the service had yet to be resolved. There was capacity to deliver some anticipatory care packages for frequent attenders within ED as part of a developing programme. As part of this on-going work, the trust was working with the local NHS mental health services to improve their liaison psychiatry services, and access for people with a learning disability and mental health disorders.

- The trust worked in partnership with the community ED team staffed by Solent NHS Trust. This team consisted of specialist nurses, therapists and a social worker. They facilitated discharge at the point of admission to the ED.

Meeting people's individual needs

- There was a private room where people whose family members were seriously ill could speak with staff. There was a poster in this room, highlighting a local low-cost facility where families could stay overnight whilst their relatives were in hospital.

- Staff did not demonstrate an understanding of the care needs for those patients with a learning disability. They had not had awareness training and could not describe reasonable adjustments that could be made in the emergency department. There was also a lack of understanding about reasonable adjustments for a patient who might have loss of hearing or sight. One nurse told us there was a learning package of information available for nursing staff to use.

- There was, however, a good understanding of the care requirements for those people living with dementia, and their relatives were allowed to stay with them at all times.

- There was good provision for people with mental health needs, including a quiet room where they could await the arrival of the mental health team. People attending with mental health problems had a comprehensive assessment taken. This included a suicide risk screening and a capacity assessment. Referral to a mental health team was usually made in a timely manner.

- Translation and interpreter services were available, but were not well used in the department. Staff told us they tended to use family members or hospital staff where required. Reasons why family members, in terms of privacy and confidentiality, should not be used as interpreters, were not being considered. The trust had an established interpreter training course for staff.

- Advice leaflets were only available in English, and not in other languages which may have been important for Southampton's population and for Southampton as a port with many foreign visitors.

Access and flow

- The service had not achieved the national emergency access target, for 95% of attendees to be admitted, transferred or discharged within four hours, between July 2013 and July 2014.

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- ·At the time of inspection there were national pressures on emergency departments, and the trust also had an outbreak of Norovirus requiring many people to be urgently transferred to ward beds for acute care, and several bays and wards were closed as an infection control measure. The percentage of patients seen within four hours was highly variable and the trust was, at times, substantially below this level.
- In January 2015, the trust was on black alert for a third of the month (21 out of 62 half days), compared to January 2014, when it was on black alert for two out of 62 half days. The ED performance was 84.1%.
- The percentage of emergency admissions via ED waiting 4-12 hours, from the decision to admit (DTA) time until being admitted to an inpatient bed, fluctuated, but was regularly higher than the national average (approximately 5%).
- The percentage of people who leave ED without being seen was consistently higher than the national average between April 2013 and May 2014 but was also well below the accepted national quality target of less than 5%.
- The number of ambulance handovers delays over 30 minutes was low when compared to other trusts (November 2013–March 2014).
- The trust executive staff, senior clinical and operational staff, and site managers, were working to minimise the risks, manage the on-going issues, and mitigate the impact upon other patients in the hospital.
- The pressures in the ED meant that patients temporarily waited on trolleys in corridors. People were moved based on clinical need rather than on their queuing time.
- The operational staff worked closely with clinical staff of all areas to ensure all patient moves (in and out of the department) were facilitated as quickly as possible. This also involved discussing with local trusts the position re 'outlier' patients belonging to them, and if they could be repatriated. On-going discussions were held at regular intervals, and this involved ambulance staff, social services and other external agencies.

Learning from complaints and concerns

- The children's department had a complaints and comments facility called 'Pants & Tops' where attendees or their families wrote comments on a board. However, the comments documented in this format were non-permanent, and no record of them was kept for learning or to ensure that all comments left on the board were seen by staff.
- Young people in the department said it was "for young kids who can't write" and "very babyish", and said they would not consider using it as a comment facility.
- A compliments, complaints and comments status form was generated weekly by the patient support services department.
- Complaints were formally recorded, and handled effectively and confidentially. The matron asked if the complainant wished to meet with her to discuss the matter further, and letters were sent outlining actions taken.
- Lessons learned from complaints were known to the teams within the department, and also the relevant follow-up. Within the adult department, complaints were recorded and fed back to the senior staff. These were then reviewed and action plans made to ensure learning and team-sharing.
- There was little obvious signage or leaflets about the patient support services team who dealt with complaints and concerns. We asked people attending and their families, and only four out of 11 patients knew what the service was, or how to access it.

Are urgent and emergency services well-led?

Good ●

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

The department had a vision and strategy for the planned future of the service. Governance arrangements were appropriate, and risks and quality were being monitored and addressed or escalated. Staff were positive and engaged, and described the internal culture as strong open leadership, mutual trust and respect.

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Senior staff described the CEO as "inspirational, hands-on and patient-focused". Junior staff told us she was regularly seen in the department, even out of hours, and that she talked frequently to patients and relatives, as well as to staff. Staff were well engaged and there was a culture of innovation and learning.

Vision and strategy for this service

- Senior staff described the vision and strategy for their department, outlining the parameters of a safe quality service. This included plans to increase nursing staff numbers to meet the increased capacity demand, continuing use of a successful community in-reach team, and working with partners.
- Staff of all grades within the department were able to demonstrate understanding of this vision and the relevant strategy underpinning it. They told us they adhered to these values, and that safety and quality were the two "daily guidelines for practice".
- The vision and values had been developed with the integration of staff opinions.
- Progress against departmental objectives was rigorously monitored, and outcomes fed back to staff.

Governance, risk management and quality measurement

- There was evidence of a multi-professional governance framework. Senior staff described in detail the governance arrangements and interdisciplinary meetings that took place, and the inter-connections between operational, managerial and clinical staff.
- Governance meetings were reviewed, and senior staff said there was a full understanding of performance being managed, with financial information, quality parameters and departmental planning being shared. However, two staff told us they were not convinced that learning from audits was always shared across the most appropriate teams.
- The service had a risk register which included all known areas of risk identified in the ED. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the trust's risk register, where they were presented to the trust's executive committee and were reviewed regularly.
- Debrief sessions were held by senior clinical staff after difficult clinical situations.

- Staff told us they felt fully supported by their clinical leads and senior managers to address any concerns they may have.

Leadership of service

- Leaders of both clinical and non-clinical services, were said by staff to be "visible and approachable".
- Nursing and medical staff told us the senior clinical and managerial staff had the knowledge, skills and personal integrity to effectively lead their department.
- Staff of a variety of grades and professions told us it was a supportive department in which to work, and that senior leads were "very hands on, with particular expertise and skills".
- Debrief sessions were held by senior clinicians after difficult clinical situations.
- Some nursing staff we spoke with were not sure of roles within the department, or those specific accountabilities. This extended to not always knowing which nurse was in charge of the shift. We were told a recent initiative was for a nurse to wear identifiable clothing; however, some staff on the early shift were not sure who was in overall charge, and we were offered three different names.

Culture within the service

- Staff we spoke with described a culture of learning, honesty and trust.
- Staff told us that the ED consultants worked well with their counterparts in medicine and surgery.
- A senior member of the medical staff praised "a strong team of doctors and nurses; we work well together for better patient outcomes. Sometimes there are high levels of stress but we support each other through those".
- A senior member of nursing staff said "we are a great team who respect and value each other. That becomes even more obvious when the pressure is on".
- There was a trust staff award scheme, and considerable numbers of ED staff had been recognised within this. Director of Nursing Awards and Matron Employee of the Month awards were available to recognise excellence.
- There were advertised study sessions to help embed or change culture within the department.

Public and staff engagement

Urgent and emergency services

- The ED matron kept copies of feedback and letters of comment or complaint. In each area of the department, there were public information boards containing safety information, details of the NHS Friends and Family Test, and nurse staffing for the day.
- At Christmas time, one of the nurses had approached local companies to donate gifts to the department. All children and young people attending on Christmas Day were given a small gift.
- A local branch of Healthwatch undertook a visit to the department and shared their findings with the trust.
- Senior staff met regularly with departmental staff, both clinical and managerial, to discuss any issues of concern or update. We were told by many staff that the CEO had an "open door" policy and welcomed unsolicited comments on the work of the department.

Innovation, improvement and sustainability

- The department supported innovation and improvement; for example, improvements to practice were actively introduced by the nursing research team who worked on site, staff were involved clinical audit, and staff developed projects as part of the trust clinical academy award leadership development programme.

- The Pit stop was introduced as a new quality service improvement to assess patients arriving by ambulance and decrease ambulance queuing times. The service was led on a shift basis by nurses of band 6 or above, to undertake the initial observation and assessment of patients and streamline patients for medical assessment. The service was described as "a work in progress", as it had only been in place for six weeks when we inspected.
- The Pit stop initiative was a multi-professional initiative that developed out of the ED matron's 'no ambulance queuing' project, developed with support from the trust Leadership Academy. The project was completed a minimum of three months earlier than scheduled. With fines of £2.44 per minute on ambulance waiting, the project had reduced the monthly total from 385 hours to 50, constituting a saving of £169,092 to the trust.
- The coloured name band scheme was introduced as a direct consequence of investigating falls within the department. Staff would know, at a glance, which patients had specific requirements such as a high risk of falls, because of the coloured, highly visible name bands.

Medical care (including older people's care)

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

The University Hospitals Southampton NHS Foundation Trust provides cardiology, gastroenterology, respiratory medicine, endocrinology, haematology, oncology and stroke services within the medical services. The trust also provides services to elderly patients and those living with dementia. The clinical services at the Southampton General Hospital are structured within four divisions, namely A, B, C and D. Most medical services and older people's care are a part of division B. Oncology is provided for within Division A and stroke services within Division D. There is a 47 bedded acute medical unit (AMU), a five bedded GP AMU, and an ambulatory care unit (ACU). All these services are provided at Southampton General Hospital.

We inspected the ACU, AMU, stroke unit (F8 ward), elderly care and dementia wards (G5, G6, G7, G8 and G9 wards), general and speciality medicine wards (D5, D6, D7 and D8 wards), isolation wards (C5 and D10 wards), coronary care unit (CCU) and the cardiac short stay ward.

We spoke with 51 patients including their family members, and 110 staff members including clinical leads, service managers and matrons, ward staff, therapists, junior doctors and consultants, and other non-clinical staff. We observed interactions between patients and staff, considered the environment, and looked at care records and attended handovers. We also reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

The medical care services required improvement in some aspects of patient safety, such as nursing staffing levels, infection control procedures, and availability and/or management of equipment and environment. There was a consistently high number of medical patients cared for on surgical or other non-medical speciality wards, where nursing staff did not always feel they had the appropriate skills. The environment was clean. Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm free care.

There were appropriate procedures to provide effective and responsive care. Care was provided in line with national best practice guidelines, and outcomes for patients were often better than average. Staff had appropriate training to ensure they had the necessary skills and competence to look after patients. Patients had access to services seven days a week and were cared for by a multidisciplinary team working in a co-ordinated way. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

Patients received compassionate care that respected their privacy and dignity. However, we observed mixed sex accommodation breaches on AMU 1 and on the cardiac short stay ward. The staff were reporting when

Medical care (including older people's care)

patients needed to be cared for in a mixed sex bay on AMU, but the staff on the cardiac short stay ward did not recognise these breaches. Patients told us they felt involved in decision-making about their care.

Services were developed to meet the needs of the local population. However, the hospital experienced difficulty meeting the demands for its medical services and this resulted in long waiting times for admission from A&E. There was specific care for patients living with dementia and mental health conditions. There were arrangements to meet the needs of patients with complex needs and this including discharge arrangements. The trust was working with partners to decrease delayed patient discharges, and was also working to improve its internal processes to ensure daily discharge targets could be met.

There were effective governance arrangements, and staff felt supported by division and trust management. The culture within medical services was caring and supportive. Staff were actively engaged and the division supported innovation and learning.

Are medical care services safe?

Requires improvement 🟠

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

There was a shortage of nursing staff on all the medical wards and the acute medical unit (AMU). The trust was using high numbers of agency and bank nurses, and agency staff had good induction to wards. However, planned staffing levels were not always met and there were a high number of medical outliers on wards where nursing staff did not always feel they had the specific training and skills to care for patients.

Equipment was regularly checked, although we found gaps in resuscitation equipment checks on some medical wards. The patient facilities on the cardiac short stay ward and G8 ward needed improvement to support appropriate personal care facilities for patients. Action was being taken to ensure harm free care; incidence of pressure ulcers and falls, for example, were higher than expected. The incidence of pressure ulcers had fallen slightly over the last year, but rates of falls and catheter urinary tract infections remained the same.

The trust infection rates were lower than average for C. difficile, but higher than average for MRSA. The environment was clean; however, staff did not follow the trust's infection control policy consistently. During our announced inspection, we observed that in the AMU and medical wards staff did not regularly wash their hands after attending the patients. In the AMU, we observed staff entering in and out of the isolated side room without using personal protective equipment (PPE), such as gloves and aprons. We addressed the concerns related to the infection control with the trust. On our unannounced inspection, we observed that staff regularly washed their hands in between patients, used PPE and were following the trust's infection control policy.

Incidents were reported and there was feedback, learning and improvement to services as a result, although learning from incidents was not always shared amongst the junior doctors.

Medical care (including older people's care)

Medical staffing, particularly consultant level cover for emergency care, was appropriate and covered medical outliers well. Patients were appropriately escalated if their condition deteriorated. Medicines were always stored appropriately.

Staff had good knowledge about safeguarding patients, and were aware of the procedures for managing major incidents, Winter pressures and fire safety incidents.

Incidents

- Between October 2013 and September 2014 medical services reported 119 serious incidents (SIs) through the National Reporting and Learning System (NRLS). Of these incidents, grade 3 and 4 pressure ulcers, and slips, trips or falls accounted for the highest number of incidents.
- Staff we spoke with stated they were encouraged to report incidents. Nursing staff knew how to report an incident and said they reported incidents frequently on the electronic reporting system, which was easy to use. Nursing staff told us they received feedback on the incidents they had reported. Minutes of monthly ward meetings confirmed that the themes of incidents were fed back to staff.
- The junior doctors told us they were encouraged to report incidents, but some did not always receive feedback from investigation findings.
- Themes from incidents were discussed at ward meetings, and staff were able to give us examples of where practice had changed as a result of incident reporting. Medical staff gave us an example of where new rationale was made and practice was changed for administering intravenous (IV) Morphine. This change was put in place following a serious incident related to administration of IV Morphine.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, in response to a high number of incidents related to pressure ulcers, the trust had introduced the 'turnaround project' or intentional rounding (where nursing and healthcare assistant staff regularly check on patients every two hours) on all the medical and care of the elderly wards. Staff did various checks on patients, such as comfort

checks, hydration, nutrition, continence, equipment, positioning, mobility and skin survey. Patient records we looked at showed these rounds were undertaken every two hours.
- Mortality and morbidity meetings took place on a monthly basis at which any deaths that had occurred in the department were reviewed, root causes analysis following incidents were discussed, and any lessons to be learnt were shared.
- The trust had robust systems and processes for action and dissemination of the Central Alerting System (CAS) alerts. CAS is a web-based cascading system for issuing patient safety alerts, important public health messages, and other safety-critical information and guidance, to the NHS and others, including independent providers of health and social care. The CAS alerts were received from the trust's central source to the medicine care group. The health and safety lead nurse logged these alerts on a database and took a specified action, such as informing all the ward managers with instructions. Each ward manager was required to return a proforma detailing that they had completed the actions required following the alert, and any outcomes for their ward. The health and safety lead nurse reported the updates and outcomes from these alerts to the care group clinical governance meeting on a quarterly basis.

Duty of Candour

- Staff we spoke with were familiar with the concepts of openness and transparency, and could give us examples of how these were actualised when managing safety incidents.
- Senior staff in the divisional management team were aware of the Duty of Candour principles and what the regulations stated. However, there was inconsistency in the staff awareness of the requirements of the newly introduced Duty of Candour regulations. Staff had yet to received training or guidance on the Duty of Candour.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. For medical services, prevalence rates of all grades

Medical care (including older people's care)

of pressure ulcers had fallen slightly over the time period, whilst rates of falls and catheter urinary tract infections had remained the same (July 2013–July 2014).

- All wards had information displayed at their entrance about the quality of the service and this included safety thermometer results. There was information about infection control measures, results of friends and family tests, numbers of complaints, levels of staff absenteeism, mandatory training update, and numbers of patient falls, new pressure ulcers, new urinary tract infections (UTIs) and new VTEs (blood clots).
- Between January 2013 and November 2014, there was a total of 536 pressure ulcers recorded across 19 medicine wards, with a prevalence rate of 7.1%. The prevalence rate was highest in wards G9 (10.7%) and the medical/respiratory HDU (13.0%).
- Between January 2013 to November 2014, there was a total of 488 falls across 19 medicine wards, with a prevalence rate of 6.4%. This rate was highest on ward G9 (11.1%) and D8 (9.6%).
- Additional actions were being taken to reduce pressure ulcers during 2014 -2015 such as improved training, and classification and review of pressure ulcers by the tissue viability team. The tissue viability team reported a trust wide fall in the incidence of pressure ulcers towards the end of the year.
- In response to high number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification by using 'falls risk assessment tool' and developing comprehensive action plans. Throughout our inspection we saw that patients at high risks of falls were clearly identified on all wards, and actions were taken to minimise the risk, such as the use of red non-slip socks and low level beds.

Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean, and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and was marked as ready for use with 'I am clean' labels.
- During our announced inspection, we observed that staff did not follow the trust's infection control policy consistently. We observed that in the AMU and medical wards staff did not regularly wash their hands, or use hand gel, after attending to patients. In the AMU, staff were entering in and out of the isolated side room without using personal protective equipment (PPE), such as gloves and aprons.
- During our announced inspection, the trust had an outbreak of Norovirus. As a response to this situation, the trust had to close some of the medical and care of the elderly wards and patient bays. These wards and areas were overseen by the infection control team. We observed staff did not use PPE in the ward bays which were closed due to outbreak of Norovirus.
- We addressed the concerns related to the infection control with the trust. On our unannounced inspection we observed that staff regularly washed their hands in between patients, used PPE and were following the trust's infection control policy.
- Staff adhered to the trust's 'bare below the elbows' policy in clinical areas.
- Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed. Data provided by the trust showed that 91% of the staff across division B, of which medical services was a part, had completed hand hygiene training in the last 12 months. Hand hygiene audits from June 2013 indicated the clinical areas achieved at least a 90% compliance rate with the trust's hand hygiene standards.
- The trust's infection rates for MRSA were higher when compared to trusts of similar size and complexity. The trust's infection rates for C. difficile were lower when compared to trusts of similar size and complexity. Patients admitted to the hospital were screened for MRSA. Between 2013/14 medical services did not have any case related to MRSA.

Environment and equipment

- We observed that each ward area had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly, to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due.
- The portable appliance testing (PAT) was overdue on four out of eight items of small electrical equipment we looked at on F4M and G8 (care of the elderly) wards, including one which was overdue from 2009.

Medical care (including older people's care)

- There were daily checks of resuscitation equipment on most of the medical wards and AMU, and these checks were documented. We found random gaps in these checks on D7 and G9 wards in the months of August to December 2014.
- We found equipment such as commodes, bedpans and urinals were readily available on the wards we visited. However, student nurses and healthcare assistants reported that there was a shortage of pulse oximeters, blood pressure machines, bladder scanners and some other basic equipment in some departments. We raised our concerns with the director of nursing who instigated an audit of basic equipment across the wards.
- The trust had a contract with an external company for supply of beds and pressure relieving equipment. We were told by the trust that the company was having difficulty meeting the demand in a timely way, and the trust was having ongoing discussions about how to resolve the issues. There were concerns that delays in availability of equipment were contributing to pressure damage in some vulnerable patients.
- Ward staff told us they had good access to equipment needed for pressure area care. However, at the time of our inspection, three patients in ward D6 had been waiting for pressure relieving mattresses to be delivered for more than 12 hours. Nursing staff on this ward were in a process of completing an incident form related to this situation.
- The nursing staff on the cardiac short stay ward told us that the ward was originally designed as a day unit, but later on became an overnight ward. This had resulted in the environment not completely meeting the needs of patients; for example, the showers on this ward were in the ward reception area. Staff told us this had frequently compromised patients' privacy and dignity, as patients had to walk in their gowns from their bed to the shower. The ward also lacked recreational facilities, such as bedside televisions. The day room was used as a treatment place, and as a waiting area for patients.
- The G8 (care of the elderly) ward, which was a 28 bedded ward, had the facility of only one assisted shower room. Staff on this ward told us this was not sufficient for patient care, and had led to delays in assisting patients with personal care. Staff told us that this issue had been escalated on the risk register.

- We observed how elements of dementia-friendly design were incorporated into the care of the elderly ward areas; for example, a colour coding system was used for different bays, and pictorial signage was being used.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges when necessary. Checks on the temperature of medicines fridges were completed on all the wards we visited. Controlled drugs were managed and stored appropriately.
- There was a good system of electronic prescribing across the trust. Staff we spoke with told us the support from the pharmacy service was good. The medical wards had support from pharmacy technicians to assess and maintain patients 'own drugs' (POD). Pharmacy staff were accessible to facilitate discharges.
- We found that processes for the removal of out-of-date and no longer required medicines were not effective on G7 ward. We found an accumulation of non-stock dispensed medicines in the medicines cabinet of G7 ward. Staff told us these medicines had been accumulating since October 2014, due to lack of pharmacy technician time to process.
- Staff told us that when patients were transferred from AMU to medical wards, sometimes there was a delay in receiving patient-specific medicines. This had led to delay in administering patient medicines.
- Ward sisters were aware of medicine incidents which happened on their wards, and learning was taken from these incidents.
- Patients told us they were usually given their medicines on time. They also said medicines were explained to them, and they were told about risks associated with taking medication.
- We observed staff giving patients medication only after correct checks were made. Nurses undertaking drug rounds were protected from interruptions.
- Staff had good access to information about medicines.
- Oxygen was usually piped to patient areas, and where cylinders were used, such as on emergency trolleys, they were correctly stored, and there was an online system to request replacement cylinders.

Records

- Records were in both paper and electronic format, and all healthcare professionals made their notes in the same place. Patient records were well maintained and

completed with clear dates, times and designation of the person documenting. The records we examined were written legibly and assessments were comprehensive and complete, with associated action plans and dates.

- Separate documents within the notes were available for patients presenting with sepsis, stroke and transient ischaemic attack (TIA). The appropriate risk assessments were completed for patients at risk of pressure ulcers or falls.
- A patient transfer checklist was completed for all patients transferred internally to another ward; this information was filed in the patient's notes. We saw a checklist that had been completed, this included information to ensure they continued to receive appropriate care and to minimise any risks.
- The medical records of these patients demonstrated that they were reviewed regularly by medical consultants and junior doctors.
- Patient information and records were stored securely on all wards.

Safeguarding

- There was a safeguarding policy and procedures in place, and staff were aware of these.
- Staff told us they had attended training in adult and child safeguarding. Information provided by the trust indicated that 61% of staff working across division B, of which the medical services were a part, were up to date with adult safeguarding training.
- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. For example, a member of the nursing staff working on the AMU and stroke unit was able to give examples of when they had used the trust's safeguarding policy to raise concerns.

Mandatory training

- Mandatory training covered a range of topics, including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance training. Staff told us they were up to date with their mandatory training.
- Training figures provided by the trust as of November 2014 showed completion rates varied across staff groups. The figures were RAG (red, amber, green) rated to indicate the compliance level, with red below 60% of

compliant staff, amber 60 to 89% of compliant staff, and green 90% and above of compliant staff. For nursing staff across division B, of which the medical services were part, the majority of training was green (above 90%), with the exception of child protection level two: 68%; conflict resolution: 77%; and consent: 33%.

- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. Data provided by the trust indicated that in the last 12 months 80% of staff working across division B, of which the medical services were part, had local induction.

Assessing and responding to patient risk

- Risk assessments were undertaken for individual patients in relation to venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- There were clear strategies for minimising the risk of patient falls on AMU and other medical wards. Staff on these wards demonstrated a good understanding of the causes of falls and how to avoid them.
- The medical wards and AMU used the medical early warning score (MEWS), a scoring system that identifies patients at risk of deterioration or needing urgent review. Medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. The completed MEWS charts we looked at showed that staff had escalated patients appropriately, and repeat observations were taken within the necessary time frames.
- Situation, Background, Assessment, Recommendation (SBAR) labels were used in patient records to easily identify deteriorating patients. SBAR is a recognised communication tool to ensure that appropriate patient information is handed over and an adequate response is received.
- Nursing staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- Patients admitted at night were either seen by the on-call consultant or the next morning by the consultant in charge of their care. We observed that patients with raised MEWS were escalated appropriately to the 'hospital at night' team. The action plans for these patients were discussed at the night handover.

Medical care (including older people's care)

- There was a critical care outreach team which supported ward staff in managing deteriorating patients. Staff across all wards stated that this service was responsive and supportive to staff.

- There were 55 medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition). We visited surgical wards (D4, E3 and E5), which had medical outliers. Staff on these wards told us that only the medical patients with lower acuity and lower risks were transferred to these wards. The risk assessments and documentation for the medical patients were transferred and reviewed on the wards in a timely manner. Staff attempted not to transfer these patients to a different ward unless clinically indicated.

Nursing staffing

- Nursing numbers were assessed using the national Safer Nursing Care Tool, and NICE guidance there were identified minimum staffing levels. Planned and actual staffing levels were displayed at the entrance of every ward.

- All staff we spoke with, from the management team to healthcare assistants, recognised nursing recruitment as a major safety risk to the service. It was captured on the directorate risk register. The management team told of various measures, such as open recruitment days and overseas recruitment initiatives, which they had put in place to decrease the vacancy factor. All ward-based staff were aware of these initiatives, and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.

- Where shortfalls in nursing numbers were identified, temporary staff from NHS Professionals (NHSP), or from an agency, were used to ensure that there were adequate numbers of registered nurses to meet patients' needs. However, staffing rotas for the month of November 2014 showed us that on three wards, D6, D7 and D8 wards, planned nursing staffing levels were not met on several occasions. For example, in November 2014, registered nurse staffing levels of 1:8 during the day were not met on D6 ward on nine shifts, for 10 shifts on D7 and for six shifts on D8. There were six shifts across these wards where actually staffing was one nurse less than planned at night. On most of these occasions, a higher number of healthcare assistants were on the rota in place of nurses, to make up numbers, as the trust was not able to fill the vacancies using the agency staff. Staff on the wards told us this was "inadequate" and "unsafe" for the patients.

- We attended an agency staffing meeting where nursing vacancies, sickness and patient acuity were reviewed. The trust was proactive and supported the use of agency nurses where required to meet patients' needs.

- Agency staff told us they were given a good local induction and handover at the beginning of their shift. The ward staff were able to request to use the same agency staff who had an experience of working on that ward, in order to maintain continuity in patient care.

- The vacancy rate on AMU was 20%. In spite of the high vacancy rate, nurses told us they felt safe in delivering patient care, and were supported by additional staffing from different wards and bank nurses.

- Staff on the medical and care of the elderly wards told us they were often requested to attend other wards or AMU, where there were shortages in staffing level. They found it very unsettling as this was happening routinely.

- Medical patients were regularly cared for on surgical or other non-medical wards. Wherever possible, staff tried hard to ensure these patients were generally more stable, and had lower dependency and acuity needs. Nursing staff told us that only patients with a lower dependency were outliers. One ward manager described how they personally went to assess a patient on AMU as they were concerned about the appropriateness of the patient moving to a surgical ward. The trust capacity management and escalation plan offered guidance for staff on how to manage the risks associated with outlying. A standard operating plan within medicine supported this document.

- Senior nursing staff on the wards told us that the low staffing level meant that their supervisory role could be achieved only on some occasions, as they were required to fill the staffing vacancy.

- Staff told us that where patients required one-to-one care, additional staff were employed. We observed evidence of this on AMU.

- Patients told us the staff and the units were busy, but the nursing staff looked after them and they did not have to wait long for help or care.

- The nursing handovers which we observed were good. There was a thorough discussion of each patient, which included information about their progress and potential concerns.

Medical care (including older people's care)

Medical staffing

- There was a consultant cover on the AMU from 8am to 10pm, seven days a week. Consultant ward rounds on AMU took place twice a day. During the day all new patients on the AMU were seen by a consultant within one hour following their admission.
- Staff told us there were sufficient consultants and doctors on the wards during the week. Junior doctors felt there were adequate numbers of junior doctors on the AMU and wards out of hours, and that consultants were contactable by phone if they needed any consultant support.
- Guidance from the Society for Acute Medicine and the West Midlands Quality Review Service (2012) suggests that a consultant should be on site or be able to reach the acute medical unit within 30 minutes. The medical staff and the service leads confirmed that this guidance was being met across the medical services.
- There was a doctor trained in the speciality of general internal medicine or acute internal medicine at level ST3 or above, or equivalent staff and associate specialist (SAS) grade doctors available at all times on the AMU, in line with the above guidance.
- On all the other medical wards, patients were seen by a consultant between two and five times a week, or more frequently if their clinical condition required. Patients were not being reviewed by a consultant at least once every 24 hours as routine. Over the weekend, the on-call consultant saw all new patients, and acutely ill patients were seen daily.
- The trust had developed a specific role for an 'out of hours' consultant. The 'hospital at night' team was led by the 'lead consultant for out-of-hours' (work). We observed the medical handover with the 'hospital at night' team. The team consisted of one surgical and one medical junior doctor (foundation year 2), a medical registrar, a junior doctor (foundation year 1) and two nurse practitioners. In the handover, staff discussed each patient that was highlighted on the doctor's work list (which was an electronic handover for doctors), their progress and any potential concerns. There was a clear discussion around the action plans for all the high acuity patients across the medical services.
- Medical patients who were on surgical wards were seen daily by junior doctors. These patients were seen by medical consultants and medical doctors at least twice a week.

- Patients who were admitted to the acute bays of the stroke ward were seen daily by the consultants. Patients admitted to rehabilitation bays of the stroke ward were seen by the consultant twice a week.
- All the doctors were trained in advanced life support (ALS).

Major incident awareness and training

- Staff we spoke to were aware of the procedures for managing major incidents, Winter pressures on bed capacity, and fire safety incidents.
- Emergency plans and evacuation procedures were in place. Staff were trained in how to respond to major incidents.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds and medical patients had to be cared for on a surgical ward. Senior nursing staff on all the medical and older peoples wards, and AMU, attended daily bed management meetings. These meetings enabled managers and staff to gain updated information as to the activity in the emergency department and the availability of beds on ward areas.
- There was an outbreak of Norovirus in the hospital when we visited. As a result of this some of the medical and care of the elderly wards were closed. Medical patients were being cared for on other speciality wards. The hospital ensured that continuity of care was maintained, and these patients were reviewed regularly by medical doctors.

Are medical care services effective?

Good 🟢

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

Care was provided in line with national best practice guidelines. Clinical audit was being undertaken, and there was good participation in national audit, with overall good outcomes. There were arrangements for ensuring patients received timely pain relief. Patients at risk of malnutrition or dehydration were risk assessed by appropriately trained

and competent staff, and referrals to, and assessments by, dieticians or speech and language therapists, were made within expected timescales. Staff had access to specialist training, but clinical supervision was not embedded.

Multidisciplinary working was widespread, and the trust had made significant progress towards seven day working. Staff received a good level of training and this included training to support people living with dementia.

Evidence-based care and treatment

- The medical services adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients.
- Compliance with NICE guidance was assessed through the medical services governance processes. The data provided by the trust showed there were 21 NICE guidelines listed under division B, of which the medical services were part. The medical services were compliant with 16 out of 21 NICE guidelines. Action plans were in place to review compliance with the remaining five guidelines.
- Local policies, such as the pressure ulcer prevention and management policy, were written in line with national guidelines, and staff we spoke with were aware of these policies.
- There were integrated care pathways based on NICE guidance for stroke patients. There were specific pathways and protocols for a range of conditions; these included heart failure, diabetes and respiratory conditions. The trust had a pathway for patients with sepsis to enable early recognition of the sick person, and prompt treatment and clinical stabilisation.
- The endoscopy department had been awarded Joint Advisory Group (JAG) accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements, to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance.
- The medical services participated in all national clinical audits that it was eligible for. The directorate had a formal clinical audit programme where compliance with NICE guidance was assessed, and the areas that had partial compliance were reviewed and action plans were made.

Pain relief

- We observed nurses and doctors monitoring the pain levels of patients and recording the information. Pain levels were scored using the medical early warning score (MEWS) chart.
- Ward staff could access support from the hospital's pain team when needed. Nursing staff on care of the elderly wards told us the pain team were very approachable and accessible.
- Patients we spoke with told us they were given pain relief when they needed it, and nursing staff always checked if it had been effective.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the medical wards. We observed that fluid balance charts were used to monitor patients' hydration status. Care of the elderly wards and medical wards had detailed fluid balance charts informing clinical decisions.
- The 'Malnutrition Universal Screening Tool' (MUST) was used in all the wards and medical units. Patients who were nutritionally at risk were referred to a dietician.
- Stroke patients' swallowing was assessed to ensure that nutrition and hydration was provided through an appropriate route.
- A red tray system was used on AMU and on all medical and care of the elderly wards, to identify patients who needed help with eating and drinking. Care of the elderly wards had mealtime co-ordinators who ensured that all the patients were given the right type of meals as advised by dieticians, such as puréed food or a soft diet. We saw that all patients had access to drinks which were within their reach. Care support staff checked that regular drinks were taken where required.
- We visited four medical and care of the elderly wards at mealtimes. We observed that nursing staff were giving assistance to feed the patients who needed support. Patients were given encouragement to take adequate oral fluids.
- Nursing staff on care of the elderly wards told us they often get support from mealtime volunteers, who assist the patients with meals. However, we did not observe mealtime volunteer support when we were visiting these wards.
- The patients told us they were always given choices for food and snack menus. However, they provided mixed views about the quality and variety of the food available.

Medical care (including older people's care)

Patient outcomes

- The hospital's mortality rates were within the expected range. There were, however, some diagnosis groups (acute and unspecific renal failure, pneumonia, cancer of the oesophagus, and cancer of the rectum and anus) that were mortality outliers. The trust was reviewing standards of care for these patients

- The trust scored in line with the national average in most of the indicators in the Sentinel Stroke National Audit Programme (SSNAP) between January and March 2014. The trust performed well in meeting physiotherapy and occupational therapy standards for stroke patients. The trust had performed below the national average in speech and language therapy input and standards by discharge for stroke patients. In July to September 2014, the trust was banded in level 'D', which is in line with the national average, and similar to other trusts.

- The trust was meeting the indicator for 80% of people with stroke to spend at least 90% of their time on a stroke unit; the trust was not meeting the indicator for 95% of patients to have thrombolysis within less than 60 minutes of arrival at hospital.

- The trust's performance in 2012 and 2013 was better than the national average in the Myocardial Ischemia National Audit Project (MINAP), a national clinical audit of the management of heart attack.

- The trust performance in the National Diabetes Inpatient Audit (NaDIA) 2013 was better than expected when compared to the England average for 16 of the 21 indicators. Four indicators were worse than expected when compared to the England average. These were meal timings, emotional support, staff knowledge and support given to take control of diabetic care.

- Emergency readmissions were within the expected range, and the standardised readmission rates compared favourably with national rates, except for clinical haematology where they were above national rates.

- Audit demonstrated that staff followed care pathways in respect of conditions such as sepsis and acute kidney injury.

- Across the hospital 561 (90%) of patients had a dementia assessment at discharge. Of these, 245 (96%) were in geriatric medicine, and 33 (94%) in general medicine (November 2014 data).

Competent staff

- Staff told us they had regular annual appraisals, but did not receive formal supervision. Staff were, however, supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities.

- Between December 2013 and November 2014, 88% of staff across division B, of which the medical services were part, had completed an appraisal. The trust target for appraisal completion was 96%.

- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to; for example, staff on the stroke ward had completed dysphagia awareness training and training for undertaking swallowing assessment. The department of neurosciences had also established 'stroke module training' which some staff had undertaken.

- Care of the elderly wards had a regular input from a dementia specialist nurse. Most staff on these wards had attended dementia training. A selective number of staff were trained to become dementia champions on the medical and care of the elderly wards we visited. The trust had plans to make dementia training a part of statutory and mandatory training as from 2015.

- The staff on ward D6, which is the respiratory ward, told us that some of the nursing staff had attended the respiratory training programme run by the trust and had found it very beneficial. The staff on the medical wards were also encouraged to attend an 'acute patient deteriorating course' which was run by the trust.

- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within medical specialities rated their overall satisfaction with training as similar to other trusts. The overall satisfaction and experience in gastroenterology was above the national average, as was the regional teaching in general medicine. Induction and local teaching in acute internal medicine was below national average, as were the handovers and overall satisfaction in neurology.

- Trainee doctors we spoke to said they were well supported and the hospital was a safe place to work.

- There were medical outliers, on surgical and other non-medical wards. Although staff tried to ensure that

Medical care (including older people's care)

these patients were more stable, with a lower level of needs, nursing staff on these wards told us they were not always appropriately trained to care for patients from different specialities.

- The therapy staff on the medical wards told us that they attended in-service training once a week and the junior physiotherapy staff also received weekly teaching related to their speciality.
- New members of staff told us that they had been well supported since joining the hospital. They had completed a trust-wide induction programme. The nursing staff had also been supernumerary on the ward for a couple of weeks, giving them an opportunity to understand processes and procedures.

Multidisciplinary working

- Throughout our inspection we saw evidence of multidisciplinary team working in the ward areas.
- Junior doctors and nursing staff told us that nurses and doctors worked well together within the medical speciality. We saw evidence of this on the AMU, medical wards and care of the elderly wards.
- Multidisciplinary team (MDT) meetings took place on the stroke ward once a week to discuss current and new patients. Staff told us this meeting was attended by various health professionals, such as nurses, doctors, physiotherapist, occupational therapist, speech and language therapist and social worker.
- Speech and language therapists attended the stroke ward regularly, and patients were also referred to clinical psychologists if necessary.
- Patients' records across medical services showed they were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.
- There was dedicated pharmacy support on all the wards we visited.
- On medical and care of the elderly wards, patients living with dementia were assessed and reviewed by a dementia specialist nurse. A dementia care pathway was used for treatment of people living with dementia.
- Clinical case managers on the elderly care wards attended virtual ward meetings which were held once a week. This meeting was also attended by other community staff, such as community matrons and district nurses. Staff told us these meetings helped in maintaining continuity in patient care after the patient was discharged from the hospital.

Seven-day services

- There was medical consultant cover on AMU seven days a week. Nursing staff and junior doctors told us consultants were on-call out of hours and were accessible when required.
- On all the care of the elderly wards we visited, consultant ward rounds took place twice a week. Over the weekend, all new and deteriorating patients were seen by the on-call care of the elderly consultant. The consultant also took a detailed board round over the weekend.
- The patients on the coronary care unit (CCU) were seen daily by the cardiology consultant. All new and deteriorating patients were seen either by the consultant or the medical registrar during the day time, and were seen by the on-call consultant over the weekend.
- Consultants worked seven days a week for stroke services. The on-call stroke consultant would see new admissions on the stroke ward and would take a ward round over the weekends. The TIA clinic was accessible seven days a week. TIA clinics were run by stroke consultants during the weekdays. They were run by either stroke consultants or neurology registrants' over the weekends. A stroke specialist nurse was available over the weekend between 8am and 8pm.
- There was a daily consultant gastroenterologist on-call for emergency gastro-intestinal bleeding (GI bleed) patients. There was a seven day endoscopy service available between 8am-6pm Monday to Friday and 8am-2pm at weekends, with 24/7 emergency availability.
- Seven day physiotherapy services were available for patients with respiratory conditions, between 9am and 8 pm. There was also a night on-call physiotherapy service for patients with respiratory conditions.
- Physiotherapy and occupational therapy services were available for patients on medical wards, the stroke ward and AMU over the weekend.
- Routine radiology ran at the weekends, with an on-call radiologist on site from 9am to 5pm. Magnetic resonance imaging was available over the weekend.
- There was a weekday pharmacy service from 9am to 5pm, with an extended dispensary service to 7pm. At weekends there was a dispensary service from 9am -1pm with a limited clinical pharmacy service provided to the medical unit (9am-3pm). The technical services

unit provided a limited service on Saturday mornings 9am -1pm. On Bank Holidays the pharmacy provided a dispensary service from 9am-1pm. Out-of-hours there was an on-call pharmacist available.

Access to information

- Staff told us they had good access to patient related information and records whenever required. The agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Staff told us that when the patient was transferred from AMU to a ward, staff could access and print the 'AMU transfer summary' from the computer. Nursing staff told us that when patients were transferred between wards or teams, staff received a handover of the patient's medical condition, and ongoing care information was shared appropriately in a timely way.
- Discharge summaries were timely (within seven days), and were provided to GPs to inform them of a patient's medical condition and any treatment they had received, when they were discharged.
- The medical staff also had access to patient information from a 'doctor's work list'. This is an electronic tool that provided comprehensive information regarding a patient's condition, and was used for patients who were acutely ill and those who were deteriorating. The medical staff found this tool very useful and it enabled them to access patient information effectively.
- The trust had developed a business case for external funding, to have electronic vital signs monitoring and early warning score recognition for use by nursing staff. This would also be linked to the doctor's work list. This was seen as vital to ensuring patient safety on wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding the treatment and care patients required.
- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, nursing staff on AMU and medical wards told us they would benefit from more comprehensive training to understand the Mental Capacity Act.

- We saw that where patients did not have the capacity to give consent to their treatment, the Mental Capacity Act 2005 was appropriately implemented. This was particularly observed on care of the elderly medical wards for the patients who had been diagnosed as living with dementia.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Staff were aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty. We did not observe any instances in medical services where an application should have been considered at the time of our visit.

Are medical care services caring?

Good 🟢

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Patients received compassionate care, and patients were treated with dignity and respect. Staff were focused on the needs of patients and improving services for patients. Patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them. Patient survey results were positive. There were arrangements to provide emotional support to patients and their families.

Compassionate care

- Results of the NHS Friends and Family Test (FFT) were displayed on every ward, and there were posters displayed encouraging patients to feed back so that they could improve the care provided. Overall, these showed satisfaction with the service provided. The average response rate of the trust for the FFT was above the England average. Between April 2013 and March 2014, 73.6% of patients were 'extremely likely' to recommend the trust to friends and family. The medical services scored 73%, which was similar to the trust average score.
- The 2013 CQC Inpatient Survey found the trust scored similar to other trusts on all the indicators.

Medical care (including older people's care)

- The 2012/13 and 2013/14 Cancer Patient Experience Survey found the trust scored similar to other trusts on 29 out of 34 indicators, and worse than other trusts for the remaining five.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn, and privacy was respected when staff were supporting patients with personal care.
- We observed many examples of caring and compassionate care, which was provided even when staff were stressed and under pressure. There was a culture of caring.
- The patients and relatives we spoke with were pleased with the care provided. They told us doctors, nurses and healthcare assistants were caring, compassionate, and responded quickly to their needs.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant.
- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regards to the way they had been spoken to. All were very complimentary about the way in which they had been treated.
- Patients on the stroke unit told us that they had been involved in developing their care plan, and understood what was in place for the future management of their stroke.
- We spoke to a relative who told us they were the "voice" of their patient and closely involved in every step of the care process, because the patient was unable to articulate. The person told us how the care staff involved them in the planning of their relative's transfer to another care setting, and how quickly the staff responded if any concern regarding care was raised.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.

Emotional support

- During our inspection we observed that staff were responsive to patient's needs, and we witnessed multiple episodes of kindness from motivated staff, towards patients and their relatives.
- The nursing staff gave us an example of where the hospital had arranged for a private ambulance to take the patient on the respiratory ward to meet her husband who was terminally ill in a nearby hospice.
- Therapy staff on the stroke unit were assessing patients using a 'mood assessment pathway' and patients were referred to a clinical psychologist appropriately.
- The hospital chaplaincy had a visual presence around the hospital and were happy to meet people to offer them support.

Are medical care services responsive?

Good ●

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as good.

Medical services were responsive to patients' needs. The acute medical unit (AMU) and ambulatory care unit (ACU) had contributed to the trust's ability to manage the increasing pressures on beds due to an increasing demand. The care of the elderly consultants worked on a locality based model and there were named consultants for patients belonging to each GP locality. This had helped in improving continuity with inpatient care, and communication with patients and families, and with other healthcare services in the community. There were 55 medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition). The patients were appropriately assessed and followed by a team of medical consultants and junior doctors.

The trust was working with partners to improve the co-ordination, safety and timely discharge of patients. However, there were an increasing number of delayed transfers of care. The main cause of delays was the provision of community services, especially care home places, to meet patients' ongoing needs. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and

on the service overall. The trust, however, was not meeting its own daily target for patients to be discharged by 11am or 2pm. A discharge steering group was developing new processes to improve fast track, simple and complex discharge arrangements, both within the trust and with commissioners and partner agencies.

There was support for vulnerable people, such as people living with dementia and mental health problems. Flexibility with visiting hours was given to carers of patients with mental health disorders.

We observed some patients being cared for in mixed sex accommodation on AMU 1 and the cardiac short stay ward. The staff were reporting these breaches on AMU, but the staff on the cardiac short stay ward did not recognise these breaches.

Complaints were handled in line with the trust's policy. Staff directed patients to patient support services if they were unable to deal with their concerns directly, and advised them to make a formal complaint. Staff told us that ward sisters investigated complaints and gave them feedback about complaints in which they were involved. Patients we spoke with felt they would know how to complain to the hospital if they needed to.

Service planning and delivery to meet the needs of local people

- The 47 bedded acute medical unit (AMU) was open 24 hours a day, seven days a week. Staff told us the unit was always busy and had alleviated pressures in the A&E department. The hospital also had a five bedded GP AMU unit, which was designed to prevent avoidable inpatient admissions and manage the increasing numbers of patients requiring emergency admission with referrals directly from GPs.
- The hospital had a nurse-led ambulatory care unit (ACU) where patients could be admitted via several different routes, including GPs. The unit followed specific ambulatory care pathways for assessment of deep vein thrombosis (DVTs), pulmonary embolism and for intravenous antibiotic treatment, which formed the majority of their caseload. Staff told us the ACU was helping to meet the needs of patients in the community who required medical intervention without the need to be admitted to the hospital.
- The care of the elderly consultants worked on a locality based model and there were named consultants for

patients belonging to each GP locality. This had helped in improving continuity of inpatient care, and with communication with patients and families, and with other healthcare services in the community. Patients found it beneficial, as they saw the same consultant every time and found it was easier to approach consultants should they need any advice.

- The staff on D6 ward told us the trust had a 'respiratory centre' based in the community. The community respiratory nurses often visited the ward to assess patients suffering with chronic respiratory disorders. These patients were followed by them after discharge into the community. Patients we spoke with found this service beneficial, as they had a point of contact from the hospital after their discharge and the nurses were very accessible.
- Inadequate capacity to manage complex inpatient psychiatric issues was identified as a risk, and out-of-hours home treatment team cover was described as patchy. The trust liaised with the local NHS mental health services to improve liaison with psychiatry services, and access for people with a learning disability and mental health disorders.
- The service leads told us that the trust was engaging with its community healthcare partners, such as Solent Healthcare NHS Trust and Southern Health NHS Foundation Trust, to develop an older people's partnership pathway. The aim was to design robust systems across acute and community healthcare services and develop safer discharge pathways.

Meeting people's individual needs

- There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.
- Staff were able to access support and advice from a learning disability nurse for individual patients and there were relevant information and tools on the trust intranet. Staff demonstrated an awareness of the 'Care Passport' scheme, where patients with a learning disability brought a document outlining their care needs and preferences, and information about themselves, for staff to reference. There were no patients who needed to use these documents during our visit.
- The trust had introduced a 'This is me' booklet for patients living with dementia, which had been developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients.

Medical care (including older people's care)

On the care of the elderly wards we saw that patients living with dementia had the booklet and it was appropriately completed. A trust 'dragonfly' symbol was used to identify people living with dementia on all the care of the elderly and medical wards.

- All patients over 75 years were screened for dementia using a recognised methodology on their admission. The dementia specialist nurse visited all the care of the elderly wards and also saw referrals on the other medical wards. Staff had completed basic dementia awareness training. The wards we visited had a named dementia champion. The trust had developed a 'dementia care bundle' which assisted staff to meet the needs of these patients.

- There was an arrangement with the local NHS mental health services to provide a liaison service for people with learning disabilities and mental health disorders. We observed a consultant psychiatrist who was employed by Southern Health NHS Foundation Trust visiting D7 ward to assess patients who were diagnosed with a mental health disorder.

- Staff on AMU told us that visiting hours for carers of patients with mental health problems were flexible. Carers could stay overnight if that was beneficial to the patients and if it was appropriate.

- Interpretation services were available and staff knew how to access the service when needed. We observed on the D6 ward that a patient who was unwell and could not speak English was supported by allowing the relatives to stay outside of the visiting hours.

- A wide range of patient literature was displayed in clinical areas, covering disease and procedure-specific information, health advice and general information relating to health and social care, and to services available locally. Patient information leaflets were not displayed in languages other than English.

- We observed mixed sex accommodation breaches on AMU. The Mixed Sex Accommodation guidance issued by the Department of Health states 'the revised Operating Framework for 2010-2011 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation …' and defines sleeping accommodation as 'areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight'. We observed how a male patient was accommodated in a side room on AMU which was facing an open female bay area where patients dressed in their nightgowns were accommodated. Nursing staff

told us this happened when the demand on the hospital was high. Patients were consulted with prior to transfer and their preference was accepted. The AMU unit ensured that these breaches were reported at trust level. The trust was aware of these issues and monitored these breaches regularly. The trust was trying to take measures to reduce this from happening.

- On the cardiac short stay ward, male and female patients were not segregated during the daytime. If these patients stayed overnight, the ward staff ensured that the male and female patients were kept in separate bays. Ward staff told us they did not report these mixed sex accommodation breaches to the trust. This therefore constituted a breach in the guidance, which had the potential to compromise patients' dignity, which was unrecognised and unreported.

- All the other medical and care of the elderly wards we visited were providing single sex accommodation.

Access and flow

- Bed occupancy in the hospital was 92%. This was consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.

- During our visit the trust identified its escalation status as 'black': the highest level, meaning that there was insufficient bed capacity to meet demand. There was a trust-wide operational group who were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted into. They also discussed any action that was required when wards were at full capacity.

- We found that bed pressures meant that the services admission pathways could not always be implemented. Emergency admissions to medical care services represented the majority of admissions. These were primarily via the A&E department or GPs. Patients were initially admitted to the AMU for assessment and diagnosis of their condition, with a maximum stay of 72 hours. If a longer stay was required, patients would be transferred to the relevant speciality ward, or to the medical short stay unit. However, due to bed pressures, patients were frequently cared for in the AMU for longer periods.

Medical care (including older people's care)

- There were 55 medical outliers at the time of our inspection (patients placed on wards other than one required by their medical condition). These patients were appropriately assessed and followed by a team of medical consultants and junior doctors. We visited surgical wards (D4, E3 and E5) which had medical outliers. The risk assessments and documentation for the medical patients were transferred and reviewed on the wards in a timely manner. Staff attempted not to transfer these patients to a different ward unless clinically indicated.

- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged, but are unable to leave the hospital due to external factors. The data provided by the trust demonstrates that between June 2013 and May 2014, there were an increasing number of delayed transfers of care.

- We were told that the main cause of delays was the provision of community services, especially care home places, to meet patients' ongoing needs. On the care of the elderly wards, staff told us there were delays in social care assessments for patients who required ongoing care. The social care assessments were not undertaken until the patients were declared as medically fit for discharge. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and on the service overall. During our inspection, 200 (16%) of medical beds had patients who had a delayed discharge.

- The records seen showed that between October 2013 and September 2014, the division B, of which medical services were part, had not met its target for 11am discharge. The figures for this ranged between 12% and 16%, against the trust's target of 20%. The trust target of 40% for 2pm discharge had not been met, with figures ranging between 29% and 36%.

- The trust had a steering group to improve discharge arrangements in division B; this had senior management and clinical support. The integrated care bureau included discharge facilitators, whose role was being developed across the trust to work with specific care groups. Discharge plans were to be commenced on admission, and within 48 hours patients would have an estimated date of discharge and a best interest assessment. This would be documented in their records. Dates indicated when patients would be assigned as medically fit and allocated for fast track, simple or complex discharge. Discharge facilitators supported ward staff with fast track discharges, were assessors for simple discharges, and case managed complex discharges with commissioners and partners, such as the local authority and in-reach co-ordinators from the local community and mental health trust. They carried out specialist assessments, such as those for NHS funded continuing care and best interest decisions. Discharge arrangements were discussed at the daily board rounds.

- The trust had planned to open the discharge lounge where patients could await transport or final discharge arrangements, such as medicines. During our unannounced inspection in January 2015, the discharge lounge was functioning. Patients we spoke with in the discharge lounge felt that they were looked after well by the nurses, and had been waiting for just under an hour following their discharge from the ward. We observed patients in the discharge lounge being regularly checked by the nurses, who were ensuring comfort, nutrition and offering them meals.

- The trust worked in partnership with the community emergency department team staffed by Solent NHS Trust. This team consisted of specialist nurses, therapists and a social worker. They facilitated discharge at the point of admission to the ED. The team were developing in-reach into the AMU to facilitate discharge. This was being piloted as a potential new role.

- Between May 2013 and May 2014, the division was consistently achieving the 18 week referral to treatment times (RTT) target against the national target, at 90%. The compliance rate for gastroenterology and geriatric medicine was 100%.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Staff directed patients to patient support services if they were unable to deal with their concerns directly and advised them to make a formal complaint.

- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint, formally or informally.

- Where patient experiences were identified as being poor, action was taken to improve their experiences. For example, staff on care of the elderly wards explained how they had responded to a higher than expected number of patient falls. Patients assessed as being at

Medical care (including older people's care)

high risk of falls were given 'identity bands', falls risk assessments were developed, and patients were offered non-slip socks. Patients with high risks of falls were also nursed in the bays which had the presence of nurses 24 hours a day, for monitoring purposes.

- Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.

Are medical care services well-led?

Good ●

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

The strategy for the medical service was to improve ambulatory pathways for the care of elderly patients, to improve the patient journey within the hospital, and to improve the seven day working service across the service. There was an effective governance structure to manage risk and quality. Staff felt supported by their ward and line managers. Staff were passionate to deliver quality care and an excellent patient experience. They said that the leadership and visibility of managers in the medical division was good. The culture within the division was caring and supportive. Staff were actively engaged, and the division had a culture of innovation and learning.

Patients were engaged through feedback from the NHS Friends and Family Test, and from complaints and concerns. Clinical governance meetings showed patient experience data was reviewed and monitored.

Vision and strategy for this service

- The service leads were clear about their priorities and had a long-term strategy for the medical services. The vision of the service was to continue to provide high quality care through an educated workforce. The medical leads told us they wanted to improve the front door ambulatory pathways, especially care of the

elderly pathways. Their priority was also to improve patient journey, and treating patients in the most appropriate area and specialism, whilst trying to break down the cycle of readmission. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge, especially for patients with long-term conditions, and for frail elderly patients with complex needs. The service was also aiming to improve the sustainability of seven day working across the service.

- The trust's vision was well recognised and owned by staff. Matrons, ward sisters and therapy staff were passionate about improving services for patients, and providing a high quality service.
- Individual wards had developed local visions or philosophies of care. Staff described to us how these had been a collaborative project involving the care team.

Governance, risk management and quality measurement

- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The medical services had a quality dashboard for each service, and this was available on the trust's intranet site. It showed how the services performed against quality and performance targets. Members of staff told us that these were discussed at team meetings. The ward areas had visible information about the quality dashboard.
- The medical services had a robust governance structure. The service had quarterly clinical governance meetings where the results from clinical audit, incidents, complaints and patient feedback were shared with staff. Minutes of clinical governance meetings showed patient experience data was reviewed and monitored.
- The service produced a monthly governance newsletter which was shared with the staff. Patient stories and lessons learnt were included in these newsletters. We were given an example of where a medical consultant had written their reflection on a complaint which had resulted from poor communication with the patient's family, and how the practice could be improved in future as a result of the complaint.

Medical care (including older people's care)

- The service had a risk register which included all known areas of risk identified in the medical services. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the trust's risk register, where they were presented to the trust's executive committee and were reviewed regularly.

Leadership of service

- Ward staff felt well supported by their ward sisters and matrons, and told us they could raise concerns with them. Staff across medical wards told us matrons were visible and had a regular presence on their ward. Staff told us that the director of nursing was approachable and helpful.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division, and in the trust.
- The student nurses told us they felt supported on the ward and received supervision training from the senior staff. They told us consultants were accessible and approachable.
- Staff told us the chief executive was often visible within the trust and was approachable. All the staff spoke highly of the CEO and told us she was an excellent role model.
- Staff told us the medical divisional leads had a visual presence on the wards and provided good leadership.

Culture within the service

- Staff spoke positively about the high quality care and services they provided for patients, and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- Staff were committed to their work and to providing high quality care for patients. We observed many examples of caring and compassionate care, which was provided even when staff were stressed and under pressure. There was a culture of caring.
- Results from the 2013 NHS Staff Survey showed the trust's performance was rated as worse than expected for three out of 28 indicators. Areas in which staff did not feel the trust performed well included staff working extra hours, staff motivation at work, and availability of

hand-washing materials. The trust performed better than expected in nine out of 28 indicators, some of which included work culture, job-specific training, job satisfaction, and incident reporting culture.

Public and staff engagement

- The trust held monthly care group engagement sessions for all staff. These sessions had a different focus every month, such as updates on both human resources policies and on training.
- The medical divisional leads also held monthly listening clinics for all the staff, where staff could raise any concerns or share an experience.
- The junior doctors told us they were able to raise concerns, and the trust conducted junior doctor forums, where they could express their views and share new ideas.
- Patients were engaged through feedback from surveys, such as the NHS Friends and Family Test, and from complaints and concerns. Other forms of engagement were not developed. Clinical governance meetings showed patient experience data was reviewed and monitored.
- The division held a 'carers' café' and a 'memory café' on a weekly basis, which were led by a dementia specialist nurse, but also had input from other specialities, such as the tissue viability nurse and the diabetes nurse.

Innovation, improvement and sustainability

- There were examples of innovative service delivery and clinical practice. This included the trust's use of electronic prescribing, link pharmacists, and clinical case managers on care of the elderly wards.
- Members of the Stroke Association visited the stroke unit once a month. They shared their experiences with the patients suffering with stroke and gave information about support available in the community. They also provided an opportunity for the patients to meet the stroke survivors.
- The therapy staff had launched a 'Winter resilience project' across the care of the elderly wards. The patients who needed intensive therapy were supported by the winter resilience team, who provided additional sessions of rehabilitation and therapy on the ward.
- The AMU matron had received an internal 'Outstanding Contribution to Nursing Award' in 2014. This was awarded by the director of nursing

Surgery

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Good**	🟢
Overall	**Requires improvement**	🟠

Information about the service

The surgery service at the Southampton General Hospital is provided across the four care divisions at the trust, namely A, B, C and D. Surgical service provision includes orthopaedics, trauma care, ear, nose and throat (ENT), dermatology, maxillofacial, gynaecology, vascular, ophthalmology, orthodontics, urology, and gastroenterology, as well as specialist services, such as neurosurgery and cardiothoracic surgery. There are 27 operating theatres, including the main theatres and ophthalmology. There are also pre-assessment and day case surgery areas. The hospital saw 35,621 patients in this directorate during the previous year. The 'hospital provider spells', which identify the continuous stay of a patient using a hospital bed, identified that within the surgical services, 33% were day cases, 31% were elective, and 36% were emergency cases.

We visited all surgery services as part of this inspection, and spoke with 21 medical staff, 18 ward or team managers, 46 registered nurses, other health professionals and healthcare assistants. We also spoke with nine specialists, who included lead nurses and the operations manager for the surgical service. We spoke with 16 patients, and examined 15 patient records, including medical notes, as part of this inspection.

Summary of findings

Surgical services required improvement to support safe care. Medical staffing was appropriate and there was good emergency cover, but there was a shortage of nursing staff, with a high number of vacancies. Agency staff were used, but they did not always have appropriate induction. The skill mix of nursing was not always appropriate for patients, and nursing staff did not always have time to meet patient's care needs. The storage of medicines in theatres required improvement to ensure secure storage facilities to reduce the possibility of misappropriation of medicines.

There was a culture of incident reporting with consistent feedback and learning. The service was taking action to reduce new pressure ulcers, and slips, trips and falls. Infections following fractured neck of femur and hip replacement were lower than the national average. The environment was visibly clean and staff followed the trust policy on infection control.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, in pain management, and in the monitoring of nutrition and hydration of patients in the perioperative period. Multidisciplinary working was evident. Staff had access to training and had received regular supervision and annual appraisal. Consultant-led, seven-day services had been developed and were embedded into the service.

Surgery

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), but some were unaware of the recent changes to DoLS.

Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect. Emotional support for patients with terminal illness was exceptional according to relatives.

Surgical services needed to improve responsiveness. The national time of 18 weeks between referral and surgery was not being met in some specialties and operations were being cancelled. Services were developing to improve the response to increasing demand, and patients had surgery based on clinical need. There were, however, capacity pressures, and a lack of available beds was resulting in patients spending longer periods in the theatre recovery areas.

There were a high number of delayed transfers of patients ready for discharge, but who were awaiting a care home or care packages. Patients were staying longer than 23 hours on the surgical day unit. There were various inefficiencies in discharge arrangements for surgical patients, with the result that many were discharged later in the day than planned.

There was support for people with a learning disability and reasonable adjustments were made to the service. But information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

Surgical services were well-led. Some staff said they felt pressurised when patient admissions fluctuated and felt that they received poor support during stressful periods. Strategic plans were addressing capacity issues, and risks were identified and being managed, or were appropriately escalated. There was positive awareness amongst staff of the values and expectations for patient care across the trust. Staff were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.

Are surgery services safe?

Requires improvement 🟠

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

There were a high number of nursing staff vacancies in surgery. Safe staffing levels were being achieved by the use of bank and agency staff, but staffing was a concern, as agency staff were used but did not always receive an appropriate induction, and patients on wards were being treated by nurses who were sometimes not from the appropriate specialty to provide skilled care. Nursing staff did not have time to fully respond to patients care needs; for example, the 'turnaround project', established to regularly review patients every two hours, was not always completed. Most medicines were appropriately managed, but the storage of medicines in theatres was not secure and action was required to reduce the possibility of misappropriation of medicines.

The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care, but incidence of pressure ulcers and falls, for example, were higher than expected. The incidence of pressure ulcers had fallen slightly over the last year, but rates of falls remained the same.

Staff had an understanding of safeguarding, but more staff in theatres needed to attend child protection training.

The environment was visibly clean and staff followed the trust policy on infection control. Infections following fractured neck of femur and hip replacement were lower than the national average.

There was access to appropriate equipment to provide safe care and treatment. Surgery staff told us they were encouraged to report any incidents, which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The hospital's surgical safety checklist was fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical staffing was appropriate and there was good emergency cover. Medical handovers were well structured within the surgical wards visited.

Surgery

Incidents

- There had been two 'never events' in the trust between April 2013 and October 2014. They occurred in trauma and orthopaedic surgery. A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented. Each never event was reviewed by the surgical quality group, which included a full root cause analysis (RCA) of the incidents.

- Between October 2013 and September 2014, surgical services reported 68 serious incidents through the National Reporting and Learning System (NRLS). The most frequently reported incident type related to grade 3 pressure ulcers. Higher numbers of incidents were also reported under pressure ulcer grade 4, and slips, trips and falls.

- All staff we spoke with said they were encouraged to report incidents. Incidents were discussed at weekly meetings. Information provided showed that all incidents in surgical services had been addressed in a timely manner.

- All incidents reported were analysed to ensure lessons were learnt. Staff in all surgical departments visited told us they were informed about incidents, and discussed any changes to practise at team meetings.

- Staff had responded to an increase in falls by improving the monitoring of patients, and when required, this was supported by the trust with extra staff. We observed there had been a clear improvement in safety. Staff told us of their awareness of a higher risk of outlier patients having slips, trips or falls. We saw completed risk assessments which had identified the risk.

- We attended a root cause analysis (RCA) meeting for the surgical vascular ward. The meeting discussed an incident, their findings and actions to be taken. On return to the ward, we observed the ward manager arranging a meeting to discuss the results with staff on duty. This meant that staff were immediately informed of all lessons learnt regarding incidents.

- We saw a communications folder within the acute surgical admission team, which included incidents, and the issues and actions arising from incidents.

- In operating theatres, the staff had implemented robust measures to reduce the likelihood of pressure ulcers developing during operations. Risk assessments were completed for patients having operations, and appropriate devices were used, such as heel pads and arm supports, to reduce pressure damage.

- During our visit we became aware of an incident whereby a patient had left one of the wards without staff being aware. We reviewed their care records and found they lacked detail. We discussed the matter with the senior management for surgery. We have since received confirmation of the action taken, which included the completion of an incident form, and staff on duty having to provide statements of the occurrence. The matron was also tasked with ensuring that all staff refresh their knowledge of the absconding policy.

- The hospital's annual report and accounts for 2013/14 set out the trust's intention to improve the hospital standardised mortality ratios (HSMR). The report outlined that all care groups within the trust would improve hospital standardised mortality ratios.

- Each speciality had an identified outcome that was specific to clinical need. The mortality and morbidity meetings across the surgical specialities occurred monthly. The information was reported through the governance structure to ensure early intervention. The data was monitored by the central team and reported to the trust board.

Duty of Candour

- During an incident investigation meeting we attended, the new Duty of Candour regulations were discussed, together with how the surgical departments would meet future incidents with openness and transparency.

- Managers were aware of the Duty of Candour regulations and told us they were in the process of cascading information to staff. Staff said they were aware of the trust's openness and transparency when things went wrong. The manager informed us that they had not had to implement the Duty of Candour regulations with regard to any incidents.

Safety Thermometer

- NHS Safety Thermometer information was displayed at the entrance to each ward so that all staff were aware of the performance in their ward or department. This included information about infections, new pressure ulcers, new catheter urinary tract infections (C.UTIs) and venous thromboembolism (VTE).

Surgery

- For surgical services overall, prevalence rates of C.UTIs have remained low throughout October 2013 and September 2014, while rates of pressure ulcers and falls have varied, with no improving or deteriorating trend.
- Between January 2013 and November 2014, there was a total of 86 pressure ulcers recorded for all surgical wards, this was a prevalence rate of 2.5%. The prevalence rate was highest in wards F7 (4.5%) and E7 (4.4%). A total of 59 falls were recorded for the eight surgery wards, with a prevalence rate of 1.7%. This rate was elevated between October 2013 and March 2014 – when 15 to 16 Falls were reported each quarter; The prevalence rate was highest in the SHDU (3.0%) but this corresponded to only four falls.
- There was a trust wide target to reduce the number of avoidable grade 2, 3 and 4 pressure ulcers by 20%. This target was not met over 2013/14. Additional actions were being taken to reduce during 2014/15. To November 2014 there had been 144 grade 2 and 26 grade 3 and 4 avoidable pressure ulcers at the hospital. There were no improving or deteriorating trend for surgical services overall to end July 2014. However, the vascular ward (D4) had reduced the incidence of avoidable pressure ulcers from seven 2013/14 to one 2014/15. The tissue viability team reported a trust wide fall in numbers of pressure ulcers towards the end of the year.
- In response to high number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification by using 'falls risk assessment tool' and developing comprehensive action plans. Patients at high risks of falls were assessed and actions were taken to minimise the risk.

Cleanliness, infection control and hygiene

- The surgical wards visited were visibly clean, with the appropriate green 'I am clean' sticker on the equipment being used.
- Hand hygiene gels were available outside the wards, bays and side rooms. Hand-wash basins were available in bays and side rooms.
- We saw Legionnaires' disease management plans, which were to protect the patient's safety regarding serious lung infection.
- Instructions and advice on infection control were displayed in the ward entrances for patients and visitors,

including performance on preventing and reducing infection. Personal and protective equipment, such as gloves and aprons, were available in sufficient quantities.
- There was a high awareness among staff about infection control. Staff followed the trust policy on infection control. During our visits we observed staff washing their hands and using hand gel between treating patients. There was adherence to 'bare below the elbow' policy in clinical areas.
- In each ward area, staff had audited performance on adherence to infection prevention and control measures; reports were shared with staff at meetings and on noticeboards.
- Infection rates for C. difficile and MRSA were below national levels for these infections.
- There were no cases of MRSA recorded since July 2014. However, patients were transferred to wards which may be used for elective surgery, when they may not have been fully screened for hospital-acquired infections. As a precaution, staff on these wards had undertaken full re-assessments of patients due to the additional risks that this posed. The trust told us that patients in all specialities are screened for MRSA on admission, however isolation of MRSA positive (nasal) patients policy, is different between medicine and surgery. Staff are aware of this so medical patients are not placed within the same bays as surgical patients to minimise any risk.
- Managers and staff completed audits to check that bacteriological screening of patients had been completed on admission, and before if it was a planned admission.
- Data provided across the trust showed that 91% of staff had completed their hand hygiene training in the last 12 months.
- In operating theatres, there were dedicated cleaning staff with clear responsibilities; their work was checked and audited.
- The doors to one operating theatre were found to be damaged to such an extent that they created a risk of infection. This was brought to the attention of the trust for urgent action, and we were told this was resolved within 24 hours.
- There was an outbreak of Norovirus in the hospital when we visited in December 2014, which resulted in

some bays and wards being closed to admissions. We observed the infection control team work closely with staff within the surgical wards to ensure the outbreak was adequately managed and controlled.

Environment and equipment

- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, was regularly checked, and documented as complete and ready for use.
- Ward managers and shift leaders checked the equipment at each shift, to ensure that emergency equipment was always ready for use.
- There was sufficient equipment to maintain safe and effective care. Staff told us they made a request to the local company who provided the equipment, who responded quickly and efficiently to their request, with no delays identified. However, we were aware of some concerns relating to delays in delivery of pressure relieving equipment in some areas of the hospital, as the company was having difficulty meeting demand.
- Student nurses and healthcare assistants reported that there was a shortage of pulse oximeters, blood pressure machines, bladder scanners and some other basic equipment, in some departments. We raised our concerns with the director of nursing who instigated an audit of basic equipment across the wards.
- Storage was a problem within the neurosurgical ward, which made the area look cluttered, despite minimal personal belongings being allowed on the ward.
- We found that doors on the thoracic theatres were unsuitable. We spoke with senior management who agreed to padlock the faulty internal theatre doors to secure them. Arrangements have been made with the estates team to request the services of a contractor to fix the faulty mechanism.
- There were no toilet amenities within the recovery area. Staff supported people to get dressed and they had to walk to the day care unit to use the toilet facilities.

Medicines

- Medicines were checked and reconciled by staff regularly, and an audit was completed to check stock and utilisation. Pharmacy staff allocated to wards checked medicine charts daily through weekdays, and provided advice on, for example, doses and contraindications.

- We found no issues or concerns with the administration of medicines. Pharmacy and nursing staff audited drug charts and we found no omissions in those medicine administration records (MAR).
- There were concerns regarding the secure storage of general medicines within theatres. The older theatres did not have lockable medicine cabinets. The newer theatres had lockable medicine cabinets but these were not locked during our visit. We addressed the matter with the senior management for surgery. They informed us that the lack of appropriate locked medicine storage cabinets was being addressed by a rolling replacement programme within theatres, which would ensure that all cupboards that required locks were replaced by Spring 2015. The matter had been identified and placed on the risk register. We were also provided with copies of risk assessments completed by the theatre management team.
- We examined the controlled drug (CD) registers and found these to be appropriately completed, with CDs checked at the beginning and end of each operating session.
- Recently, a new system had been introduced regarding the receipt of CD drugs from the pharmacy within theatres. All CD drugs arrived on a trolley which was locked. However, we saw this was not secured, which meant that it was at risk of being removed. This was brought to the attention of senior management, who informed us of the current process that is being piloted. We were informed that the trolley is not left unattended with drugs remaining inside at any time and the porter has no access to the trolley. Senior management said that following a successful pilot, the trolley would be secured to a wall with an appropriate locking mechanism, so that the co-ordinator can, if required, leave the locked trolley with drugs to be assigned.
- Medicines within the wards were stored correctly, including in locked cupboards or fridges when necessary.
- The temperature of medication fridges was monitored regularly.
- Staff were able to outline the reasons for varying doses of medicines, and were given examples of the reminder chart, which ensured that patient's safety was maintained.

Records

Surgery

- In surgical wards and theatres, we examined 15 patients' case records, which included assessments for patients treated in operating theatres. There were detailed and comprehensive pre-assessments made on patients prior to admission. Important information was raised as an alert message to anaesthetists and the theatre team, for when patients were admitted for their operation. Five steps to safer surgery checklist records were completed for all patients.
- In ward areas, nursing and medical staff used the shared assessment record to ensure risk assessments were completed; examples included checks for skin integrity, falls risk, nutritional risks.
- The wards had care plans to identify what care should be given to patients. This meant that agency nurses who were new on the wards had access to information on how to care for a patient.
- Completion of documentation was variable within the wards visited. For example, we found assessment records within the trauma and orthopaedic wards to be sparse, with some forms being incomplete, whilst records within the neurosurgical wards were completed correctly.
- Separate documents within the notes were available for patients presenting with a risk of pressure ulcers or falls. We found isolated examples of delayed re-assessment of risk following the recovery of the patient, and some elements of care planning, in response to risk of pressure sore development, were not recorded.
- Comfort rounds, also known as 'turnarounds', were undertaken every two hours; this included change of position and pressure area care as required. However, the documentation for these rounds did not consistently record all aspects of the care provided.
- Patient information and records were stored securely on all wards.

Safeguarding

- Staff in all clinical areas were able to explain safeguarding arrangements, and when they might be required to report issues to protect the safety of vulnerable patients.
- The training records within the wards visited identified that both medical and nursing staff had attended safeguarding training. This was confirmed by staff spoken with.
- The trust had reassessed staff that required level 3 child protection training; however, staff in theatres were

finding it difficult to attend this training. Trust-wide compliance was 38% in August 2014. Face-to-face training was the preference, as this was seen as more robust, but the child protection team did not have the resources to deliver bespoke packages of training to departments. E-learning had recently been developed for level 3 training, but figures were still lower than required, as the training would still take six to seven hours to complete. This was on the risk register and actions were being taken to mitigate risks; the level of child protection awareness training was 68% trust-wide and level 2 training was increasing.

Mandatory training

- All staff in surgery areas were aware of the need to attend mandatory training in issues such as moving and handling, and safeguarding. They told us their training was up to date and they were sent reminders via e-mail of any outstanding training. Ward managers kept good records of the training needs of staff, and were prompted by the personnel department reports regarding completion and performance.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. Data provided by the trust indicated that in the last 12 months 80% of required staff had undertaken local induction.
- We spoke with the education team, who confirmed there were structured teaching sessions throughout the year within neuroscience, which included the management of deteriorating patients, tracheotomy, resuscitation and percutaneous endoscopic gastrostomy (PEG) tube management.
- Occasionally, training was cancelled due to staffing shortages, but staff were given a choice of how they completed their annual mandatory training, whether by e-learning, face-to-face or ad-hoc sessions for practical work.

Assessing and responding to patient risk

- The surgical wards used the modified early warning score (MEWS) to identify if a patient was deteriorating. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these.
- Staff in some areas told us that the situation, background, assessment, recommendation (SBAR) format, which is used as a communication tool and

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which requires a clinician's immediate attention and action, was no longer in use. They told us that as the doctors were all ward-based and patients were seen immediately, this had reduced the need for SBAR. The trust told us that the tool was still in use, with copies of the tool available on all the wards in surgical services. The use of SBAR when escalating a MEWS for a patient was encouraged and paperwork audited by the matrons monthly as part of the acuity audit. The tool is taught on the acute illness management (AIM) in-house course.

- Staff were able to assess and respond to a deteriorating patient in line with policy and guidelines. We observed the management of a newly admitted, acutely unwell patient who needed resuscitation. We observed good management skills by the advanced nurse practitioner.

- We spoke with staff in the anaesthetic and recovery areas, and found that they were competent in recognising deteriorating patients. In addition to the early warning score, a range of observation charts and procedures, pathways and protocols for different conditions or operations were used.

- All theatre teams were using the five steps to safer surgery checklist, which is designed to prevent avoidable mistakes; this was an established process within the teams. We looked at the checklists which had been completed, which included, for example, the patient's identity and whether they had any known allergies. The hospital had provided audit information from January 2013, and this had confirmed there was, overall, 100% compliance with this procedure. There was an action plan for safer surgery which indicated the need for six monthly audits, which we did not observe.

- Operating theatre teams undertook discussions as part of the safer surgery guidance, which included asking if a patient may be pregnant prior to having surgery.

- Staff had knowledge of restraint, and said they had received conflict resolution training to enable them to provided distraction techniques where appropriate. Staff were aware of the required risk assessments.

- Many of the surgical wards had outliers or patients with non-surgical conditions; this included the vascular ward, which had 22 beds, 10 of which were occupied by medical outliers. Nursing staff expressed concerns that they felt inadequate to support people diagnosed with, for example, heart conditions. Staff felt they may not be able to respond to the risk of patients transferred to the ward.

- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.

- There were clear strategies for minimising the risk of medical patient falls on surgical wards. Staff on these wards demonstrated a good understanding of the causes of falls and how to avoid them.

Nursing staffing

- Nursing numbers were assessed using the national safer nursing tool and there were identified planned staffing levels. The trust told us staffing establishments were not set at minimum levels . The required and actual staffing numbers were displayed on the wards visited. Senior staff reported they were understaffed. The highest vacancy rate was in trauma and orthopaedic, which was at 28%. The records showed the current sickness level within the surgical team was at 5%.

- Vacancies were filled with bank and agency staff. The ward managers told us that some staff picked up additional shifts to support the wards, and they used bank staff. The managers told us they requested the same bank staff to ensure continuity within the wards.

- Staffing rotas demonstrated that safe staffing levels (registered nurse to patient ratio) of 1:8 during the day and 1:10 at night, were being achieved. However, staff on the wards told us staffing was a 'safety' concern. In 2014, agency staff formed approximately 16% of the surgical nursing workforce, and 18% in trauma and orthopaedics. Some agency staff said they had not received any induction to the wards they were working within.

- Patients on wards were being treated by nurses who were sometimes not from the appropriate specialty, such as patients who had gastrointestinal surgery being cared for by nurses who usually cared for patients undergoing eye surgery. The wound care support required for patients undergoing gastrointestinal surgery was not so familiar to those nurses. This affected the quality of care for patients, because their wound care was not treated by an expert member of staff. The matrons we spoke with acknowledged that issues with skill mix were of concern.

- Staff in both surgical wards and theatre said they recognised recruitment as a major safety risk to the service. It was captured on the directorate risk register.

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The management team told of various measures they had undertaken, such as open recruitment days and overseas recruitment initiatives, to decrease the vacancy factor. Staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff were seen as a priority by the trust.

- Nursing handovers occurred at the change of shift. Staffing for the shift was discussed, as well as any high-risk patients or potential issues.
- The trust had introduced the 'turnaround project' (where nursing staff regularly check on patients every few hours, change their position, and administer comfort checks). Some staff said that due to staffing issues, they were unable to complete the 'turnaround project' and carried out observations instead. They felt that the use of agency staff was affecting the quality of care, as they were spending time having to assist and mentor these staff. Patient records we looked at showed that these rounds were not always being undertaken every two hours.

Surgical staffing

- Surgical consultants from all specialties were on-call for a 24 hour period.
- Surgical consultants told us they were well staffed and did not have any concerns. Consultant vacancies in the surgical directorate was 14.6% in September 2014, and this had reduced to 2.1% by December 2014. In surgical care group the consultant vacancy was 8.6% and staff grade/associate specialists vacancy 30%. Locum use across surgery was approximately 1.73%.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours, and that consultants were contactable by phone if they needed any support. There was a high vacancy rate for junior doctors in trauma and orthopaedics (16.15%), and locum use was 17.19%.
- Consultant ward rounds varied and some took place twice a day and some twice a week. There were no guidelines to demonstrate how this was determine according to the patient pathway. During the day all new patients were seen by a doctor within one hour following their admission.
- Staff told us there were no issues with the staffing levels within theatres.

- Handovers were consistently formal and structured. During our announced visit we attended a surgical handover. The handover reviewed patient care based on the severity of their condition and any anticipated problems.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents, Winter pressures, and fire safety incidents.
- Emergency plans and evacuation procedures were in place.
- There was a bed management system that aimed to ensure patients' needs were met when there were increased demands on beds. Some medical patients were placed and cared for on the surgical wards.
- There was an outbreak of Norovirus in the hospital when we visited, which resulted in some wards being closed. The surgical speciality wards we visited had medical patients being cared for within these wards. The ward managers assured us that the needs of surgical patients were being met effectively, and not being compromised by having medical patients on the wards.

Are surgery services effective?

Good ●

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

The service demonstrated that care was provided in accordance with evidence-based national guidelines and best practice. Policies and procedures were accessible, and staff were able to guide us to the relevant information. Care was being monitored to demonstrate compliance with standards, and there were good outcomes for patients.

Patient's pain was appropriately managed, as were the nutrition and hydration of patients, particularly in the perioperative period. Staff worked in multidisciplinary

teams to co-ordinate patient care. Overall, staff had access to training, and had received regular supervision and annual appraisal. The surgical service had a consultant-led, seven day service.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), but some were unaware of the recent changes to DoLS. The education team confirmed they were continuing to roll out the training in relation to MCA and DoLS.

Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines. We found the Royal College of Surgeons' standards for emergency surgery/surgery out of hours were consultant-led and delivered.
- Local policies, such as the pressure ulcer prevention and management policies, were written in line with national guidelines, and staff we spoke with were aware of these policies.
- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ENT. This focused on thorough pre-assessment, less invasive surgical techniques, pain relief, and the management of fluids and diet, which helped patients to recover quickly post-operatively. We reviewed the enhanced recovery pathway documentation for colorectal surgery, and both major and minor open liver surgery. There was clear guidance for staff regarding the recording of pre-operative and post-operative information.
- The trauma and orthopaedic care group participated in national clinical audits, such as the National Joint Registry. This registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and monitors the performance of joint replacement implants.
- The directorate had a clinical audit programme where compliance with national (such as National Institute for Health and Care Excellence (NICE)) and local guidance was assessed. Where guidance was not being met, this was reviewed, with action plans implemented.
- Trauma and orthopaedic hip and knee treatment wards followed a post-operative pathway, which included post-operative phone calls to patients.

- The neurosurgical unit had an effective elective tumour pathway, which included pre-booked post-operative radiological imaging slots. This resulted in an average length of stay of one night for patients undergoing elective intra-cranial tumour surgery.

Pain relief

- Patients were assessed pre-operatively for their preferred pain relief.
- The records showed that patient's pain relief had been risk assessed using the pain scale found within the medical early warning score (MEWS) system.
- Patients told us they were provided with pain relief when required.
- Staff could access support from the pain management team when required.
- During an ear, nose and throat (ENT) departmental mortality and morbidity meeting it was identified that post tonsillectomy pain was not being managed adequately. This resulted in the re-design of the information leaflet, regarding the information being provided to patients on how to manage pain.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration, when applicable. We observed that fluid balance charts were used to monitor patients' hydration status.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken where required.
- The patients said they were given choices for food and snacks. However, they provided mixed views regarding the quality of the food available.
- Staff said they monitored patient's nutritional state and, where required, would make a referral to the dietician.
- The wards visited had an 'at a glance' board, which provided an overview of the patients. Areas identified included support with feeding and if the patient was diabetic. The board also identified the estimate discharge date.
- The ward had introduced protected times when visiting was not allowed. This was during mealtimes. However, during our inspection we observed visitors on wards

during these times. When we spoke to visitors, they told us they came during lunchtime to help their relative to eat, because there were not enough members of staff available during mealtimes to do this.

- There were 'red trays' to identify patients who needed help with eating. We observed one patient with a red tray being supported by staff. We asked three members of staff on the ward what the red tray system meant, and they were able to tell us.
- All patients who displayed nausea and/or vomiting post-surgery were monitored within recovery. Where applicable, suitable analgesic and antiemetic regimes were prescribed, which were identified in the patient's records.

Patient outcomes

- The hospital's mortality rates in surgery were better than the expected range.
- The division had a performance dashboard that it used to monitor the quality of care provided.
- Surgical mortality reviews were completed. The hospital's overall mortality rates were lower than expected and there were no mortality outliers (outside the expected range) for this service.
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROM) programme, the national hip fracture database, and the national joint registry.
- The PROM scores for both hip and knee replacements were better than the national average.
- The hip fracture audit showed the trust was above the England average for pre-operative assessment by geriatrician and for surgery within 36 hours. The records showed the hospital was better than England average for surgery within 48 hours and for risk of patients developing pressure ulcers.
- The bowel cancer audit data (2013) showed that 100% of patients were seen by a clinical nurse specialist, with the length of stay above five days below the national average. However, the records showed that the discussion by the multidisciplinary team (MDT) was below the national average at 44%, against the England average of 98%. However, the team explained to us that this was because tertiary patients were discussed in MDTs at local hospitals. The validated self-assessment as part of the cancer peer review cycle 2014, demonstrated that the colorectal (bowel) cancer multidisciplinary team meeting was 95%.

- The standardised risk readmission figures showed the trust was above the England average for elective patients in urology, general surgery and ophthalmology. For non-elective risk readmission, the only area of concern was urology, with a rate of 113, which was above the England average of 100.
- Patients considered their outcomes as being good. One patient said the hospital "was the best they had been to" and another said they had postponed their surgery as they wished to be seen only by the consultant at the hospital.
- 75% of patients with a hip fracture received surgery within 36 hours; this was below trust targets but slightly above national average 71%). The percentage of patients receiving a pre-operative mental assessment (78%) and fracture prevention assessment and appropriate medication to protect bones (77%) was also below trust targets. However the National Hip Fracture database records the trust as above the national average for pre-operative mental assessment (98.7%), fracture prevention at (98.5%) and appropriate medication to protect bones (94.7%).
- The trust performed better on using an assessment protocol (98%), admitted patients under joint care with surgeons and geriatricians (98%), perioperative geriatrician assessment (97%) and multi-disciplinary rehabilitation (95%).
- The trauma audit and research network (TARN) identified that 185 patients were admitted directly from the scene of the injury to the trust's hospital between 1 January 2011 and 31 December 2014, and fulfilled specific head injury criteria; for example, 180 patients had a CT scan and 176 of the CT scans had full dates and times recorded.
- The TARN also identified that 336 patients with severe head injuries were admitted between 1 January 2011 and 31 December 2014. Of these patients, 112 (33%) were transferred to this hospital from another hospital, and 145 (65%) of the patients treated at this neurosurgical unit survived up to 30 days or until discharge from hospital. The hospital's survival rates were above average, within the expected range.
- The trust performed significantly better than average in the Adult Cardiac Surgery Outcome Data published by the Society for Cardiothoracic Surgery of Great Britain and Ireland. Only one hospital did more cases and had a

lower mortality rate and this was a national specialist centre. Mortality rates in the trust were 1.44% and these were statistically better than the national average (2.5%) over the last three years from April 2011to March 2014.

- The neurosurgical unit participates in the National Neurosurgical Audit Programme and reported 30 day mortality rates of 2% which were within the expected range, but below the national average (2.05%). This was a risk adjustment (or case-mix adjustment) and took into account patient risk factors to calculate a predicted mortality rate. This meant that hospitals or consultants who see higher risk patients had their mortality rate adjusted to account for the factors that put these patients at greater risk

- The neurosurgical unit delivered had shorter lengths of stay, and below average readmission rates.

- Across the hospital 561 (90%) of patients had a dementia assessment at discharge. Of these, 71 (93%) in trauma and orthopaedics (November 2014 data).

Competent staff

- All new staff undertook competency tests to ensure they had the necessary skills to carry out their roles, such as in anaesthetics and care of deteriorating patients. We reviewed the record for a new staff member, which had been completed and signed by senior staff.

- Senior staff told us they conducted one-to-one personal development supervision meetings with staff every three months. This was confirmed by staff spoken with.

- Within the cardiac, vascular and thoracic (CV&T) wards, medical and surgical patients were nursed together. The mixture of cardiology and cardiac surgical patients was to ensure even distribution of acuity and shared learning. All CV&T nursing staff undertook a cardiac, vascular and thoracic induction course.

- Staff said they received regular clinical supervision and annual appraisal. However, between December 2013 and November 2014 the trust-wide figures indicated that only 88% of staff had received an appraisal, against the trust's target of 96%.

- New members of staff said they had been supported on joining the hospital. They had completed a trust-wide induction programme. When on the ward, they were given the opportunity to understand processes and procedures.

- The education team said they facilitated management courses for staff progression.

- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within surgical specialities rated their overall satisfaction with training as similar to other trusts, with the exception of trauma & orthopaedics, where overall satisfaction was an outlier below the national average. For the five key indicators: adequate training, induction, handover, educational supervision and clinical supervision, handover showed the least score at 62%, with clinical supervision being the highest at 92%.

Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these, together with any physiotherapists or occupational therapists as required.

- We observed a good working relationship between theatre and ward staff during our visit.

- Staff said that they could access medical staff when needed to support patients' medical needs.

- Junior doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards and the day care unit.

- Patients' records showed they were referred, assessed and reviewed by dieticians and the pain management team, when required.

- There was good interaction with the learning disability lead, who was able to provide advice and support to the surgical teams.

- There was dedicated pharmacy support on all the wards we visited, which helped to speed up patient discharges with take home medicines.

- The records viewed identified family involvement at admission to encourage effective discharge.

- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.

Seven day services

- The surgical services had a consultant presence over the weekend.

- Consultants worked throughout the week within the surgical services, and were supported by specialist registrars during the weekends.

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- Access to medical advice at night came from the surgical care group hospital at night team including nurse practitioners, an on-site registrar and an on call consultant. Nurses told us they were very responsive.
- The pharmacy was open on weekdays and on Saturday and Sunday mornings. Outside of these hours, there was an on-call pharmacist to dispense urgent medications.
- The trust provided a seven day diagnostic service which included, for example, endoscopy.

Access to information

- Staff told us they had good access to patient-related information and records whenever required. The agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us that when patients were transferred between wards or teams, staff received a handover of the patient's medical condition, and ongoing care information was shared appropriately in a timely way.
- The acute surgery unit (ASU) had a 'how 2' folder, which provided staff with information on Deprivation of Liberty Safeguards (DoLS), consent and learning disability. This information was also available on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), but were unaware of the recent Supreme Court changes to DoLS. This means that the trust must ensure that decisions about the living arrangements of a person without capacity do not amount to a deprivation of their liberty. The education team confirmed they were still rolling out training in relation to MCA and DoLS.
- Patients were asked for their consent to procedures appropriately and correctly. We saw examples of patients who did not have capacity to consent, and the Mental Capacity Act 2005 was adhered to appropriately, with documented capacity assessments.
- The records, where applicable, showed clear evidence of informed consent, which identified the possible risks and benefits of surgery.
- Patients confirmed they had received clear explanations and guidance about the surgery, and said they understood what they were consenting to.

- Staff told us consent was completed by the senior doctor and they had challenged the authorisation when it had been completed by a junior doctor.
- Where patients did not have capacity to consent, formal best interest decisions were taken in deciding the treatment and care patients required.
- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005).

Are surgery services caring?

Good ●

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Staff were caring and compassionate to patient's needs, and treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support, to enable patients to access services.

Patients said they were kept informed and felt involved in the treatment received. Emotional support for patients was exceptional according to relatives; for example, the trauma and orthopaedic ward had accommodated the needs of a patient by allowing their family member to stay overnight.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. One patient told us that "nurses always answer the 'buzzers' promptly".
- Patients said the nursing staff were kind and caring. One patient said that if they needed care again they would "get the best care possible in this hospital".
- We observed staff dealing with a patient displaying agitated behaviour with compassion and empathy.
- The NHS Friends and Family Test results were displayed within the wards. We saw posters encouraging patients to feedback their views, so they could improve the care provided. Between April 2013 and March 2014 the results showed that 74% of patients were 'extremely likely' to recommend the trust to friends and family, which equalled the national average.

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- The Friends and Family Test results showed that patients were always given privacy when being examined.
- We attended a ward round and saw that doctors introduced themselves appropriately, and curtains were drawn to maintain patient dignity.
- Patients reported that staff treated them with compassion and empathy. Comments included "staff are very brilliant, they look after me well". One patient said they thought staff were very nice and responded quickly to call bells.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- The records had individualised care plans, which involved the patient in their planning.
- Neurosurgical pre-operative assessment was additionally used as an opportunity to educate patients on their health and as well informing them of a detailed overview the care they would receive, and this was valued by patients

Emotional support

- The trauma and orthopaedic ward (F1) said they accommodated the emotional needs of a patient wherever possible; for example, the parent of a patient with a learning disability had been allowed to stay overnight, which enabled them to provide emotional support to their family member.
- A private room was made available, where more sensitive conversations could be undertaken.
- Detailed discussions had taken place with patients and relatives where relevant.

- One patient reported how they had declined earlier surgery with another consultant at another hospital as they wished to be seen by the same consultant, who they felt was better able to support their needs.

Are surgery services responsive?

Requires improvement ●

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as requires improvement.

National waiting time targets for referral to treatment (RTT) times in surgery within 18 weeks (admitted pathway) were not being met in some specialities. The trust had a plan of action, and performance against this target was improving. The trust had improved performance over the year on reducing cancelled operations and for patients with cancelled operations being treated within 28 days, but was still not meeting national targets. Bed occupancy levels in the trust were high, and the lack of available beds was resulting in patients spending longer periods in the theatre recovery areas. Services were developing to improve responses to increasing demand, which including increasing theatre use and patient admissions, Plans to manage this were coordinated with the chief operating officer and divisional teams..

Length of stay was longer than the national average for elective general surgery and for cardiac surgery and non-elective trauma and orthopaedics surgery. The trust explained this was impacted by the move of more simple surgical cases to another provider, leaving the hospital with more complex cases with longer length of stay/slower recovery rates. The hospital is a specialist centre and a major trauma unit.

Discharge arrangements for surgical patients needed to be better planned, and many patients were being discharged later in the day than planned. There were also a high number of patients who had their discharge delayed because they were awaiting a care home or care package. Patients were staying longer than 23 hours on the surgical day unit.

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The trust was meeting the target for the proportion of patients waiting less than 18 weeks (incomplete pathway) on a waiting list, and there was a better demonstration that patients had surgery based on clinical need.

There was support for people with a learning disability, and reasonable adjustments were made to the service; for example, patients were given longer preoperative assessment appointments to take account of any anxiety. Staff were able to refer any issues or concerns to the learning disability lead. Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

Service planning and delivery to meet the needs of local people

- The service had a day surgery unit, which enabled people to have minor procedures without having overnight stays in hospital.
- On the day of their surgery, patients with elective (planned) surgery were admitted to the surgical admissions lounge. They were seen by the nurse, and processed for surgery and the post-operative ward.
- The surgical management team were working to increase theatre productivity, to improve referral to treatment times. The action plan was under discussion to identify how the matter would be addressed. Within the trauma and orthopaedic team, they had halved the number of patients waiting for surgery.
- The ward matron at the day surgery unit said that the triage booking system for treatment was "challenging", as the booking team had no clinical expertise and were unaware of patient's needs. They told us they were aiming to work with the IT team to refine the information required, such as if a patient was on Warfarin.
- The neurosurgical department had developed two rapid-access urgent clinic services as an alternative to admission for spinal and intracranial surgical disorders, which had resulted in a reduced admission rate.
- The neurosurgical service had developed a 'one stop clinic' for patients with neurological tumours, during which the patients are reviewed by the multidisciplinary team, undergo peri-operative clinic review, blood tests

and radiological imaging as well as attend a consultant clinic all on the same day. This was positively received by patients who may have travelled a significant distance to attend this tertiary centre specialist service.

Access and flow

- Bed occupancy within the trust was significantly higher than the national average over the past year, at 92%. This was consistently above both the England average of 88%, and the 85% level, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Patients had a pre-operative assessment, which included, for example, testing for MRSA. The trust had a maximum limit of 12 weeks for surgery after the pre-operative assessment had taken place. Records showed that the trust was meeting this target.
- The service was under considerable and sustained pressure to meet the competing demands of emergency and elective surgery in a hospital with limited capacity. Some progress had been made in clearing the backlog of delayed operations. The theatre utilisation rate was 84.5% (June to August 2014) and the trust intended to further improve this rate, although this did not include any specific plans, or an assessment of the likely impact in other areas, such as critical care services. Health professionals told us there were no clear guidelines as to how the service was going to meet the growing demand going forward.
- An external report (February 2014) from the NHS Interim Management and Support Team, identified that the trust was not meeting referral to treatment times in 2013, and was outside the 8% tolerance afforded by the 92% standard. In the Autumn of 2013, the backlog of patients waiting over 18 weeks had not been cleared and remained high, but admitted performance was improving. This can be an indicator that patients were not always being booked in the order of the longest waiting, subject to case-mix and urgency. The report recommended better working with commissioners, better performance information, and secure plans for capacity expansion that fit with the wider health economy.
- The trust was not meeting national waiting time targets for 90% of patients admitted within 18 weeks or less (admitted pathway) for elective surgery from referral to treatment; examples included: ENT (70%), oral surgery

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(73%), ophthalmology (85%), and trauma and orthopaedics (76%) (April to September 2013). However, the trust was meeting the target of 92% of patients waiting within 18 weeks for surgery (incomplete pathway), with the exception of patients in ENT (81%) and neurosurgery (88%) (April to September 2014).

- The trust had developed a recovering plan with commissioners, and was demonstrating improvements in meeting the referral to treatment time targets. The trust had focused on the longest waiting patients (which had impacted on their admitted targets) and could demonstrate a reduction in the number of patients waiting over 18 weeks. This could be an indicator of improved probity in the selection of cases for surgery based on longest waiting, case mix and urgency.

- The Trust had an appointed lead for the Clinical Adjudication Process, which is involved in the prioritisation of operations based on clinical urgency. Cases within the trust are listed for surgery with details which enable prioritisation by the clinicians so that it is extremely rare that category 1 cases (the most urgent) get cancelled.

- Over the last year, the trust had not met the England average of 5% for patients whose operation was cancelled and who were not treated within 28 days, but there was improvement over time. The records for April to June 2014 showed the average at just fewer than 10%. This resulted in 19 patients not been seen during April to June 2014. However, this showed a marked decrease from January to March 2014, when 54 patients had not been seen. In July to September 2014, the trust met the target; there were 120 cancelled operations, and all but two were treated within 28 days.

- The number of non-clinical cancellations increased at the end of the year in December 2014. The hospital was experiencing capacity issues, and staff told us they had been on 'black alert' since December 2014; for example, there were 27 non-clinical cancellations for the week ending 10 August 2014; this increased to 55 for the week ending 7 December 2014. Systems were put in place to prioritise operations that should go ahead each day, and to give patients as much notice as possible of any cancellations.

- Patients who had received surgery were often held in recovery, as there were no beds available within the speciality service required, with no appropriate discharge planning provided. Anaesthetists told us it was not unusual for them to stay and look after patients'

recovery in theatre. They said this had a 'knock-on' effect on surgery time. Anaesthetists attended a crisis meeting each afternoon regarding the allocation of beds. They felt the timing of the meetings was too late in the day, and should be earlier to prevent a 'bottleneck"' in recovery.

- The directorate had established a day surgical unit. Nurses told us that patients should not be in this unit for longer than 23 hours. We found instances where medical outliers had been transferred to this unit and had been in an allocated bed for more than two days. Nurses told us this length of stay was not unusual.

- The daily site meeting by the care group manager and the operations manager had increased the level of micro-management of patient flow; for example, in the neurosurgical pathway, this had reduced waiting times.

- Length of stay was longer than the national average for elective general surgery, cardiac surgery and non-elective trauma and orthopaedics surgery. The trust explained this was impacted by the move of more simple surgical cases to another provider, leaving the hospital with more complex cases with longer length of stay/slower recovery rates. The hospital is a specialist centre and a major trauma unit. Length of stay was lower than the national average for neurosurgery.

- The development of the Neurosurgical Regional Transfer Unit (RTU) meant that the neurosurgical department were able to effectively deal with patient flow and had not diverted patients to other trusts for neurosurgical admissions since its opening.

- The discharge planning process started as soon as a patient was admitted onto a ward. This was overseen by the discharge co-ordinator. This detailed the reason for admission and any investigation results, treatment and discharge medication. Staff told us discharge was often delayed due to waiting for signed discharge letters and for 'to take out' (TTO) medicines.

- The records looked at identified that discharge planning was addressed in a timely manner with patients. Many patients' delayed discharge revolved around their package of care from the local authority. The trust was working with partners to improve this. During our inspection, approximately 54 (6%) surgical beds had patients who had a delayed discharge. Many were in trauma and orthopaedics.

- There was a discharge lounge within the trust, but this was not allocated to surgical patients. Staff said they felt this was detrimental to the flow of patients. The records

seen showed that the trust had not met its target for 20% of patients achieving a 11am discharge, which instead showed figures for October 2013 to September 2014 of between 4% and 16%. The trust target for 40% of patients achieving a 2pm discharge had not been met, with figures ranging between 21% and 36%.

- Staff on the acute surgical unit said diagnostics could be an issue, with only one computerised tomography (CT) scan slot allocated five days a week. This meant that patients who required a CT scan appointment were governed by availability.

Meeting people's individual needs

- The trust had a translation service, which staff said they were able to access when required.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access the leads to discuss any concerns and to receive advice.
- Staff demonstrated an awareness of the 'Care Passport' scheme, whereby patients with a learning disability brought with them a document which outlined their care needs, preferences and other useful information, which enabled staff to support their needs.
- Staff told us that people with learning disability or anxiety were encouraged to visit the hospital, so they could become comfortable with the process. People with a learning disability were given longer surgical preoperative assessment appointments, which took into account their anxiety. Information leaflets and consent forms were not available in easy-to-read formats.
- A paper summary was sent to a patient's GP upon a patient's discharge. This detailed the reason for admission and any investigation results, treatment and discharge medication.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Staff directed patients to the patient support services if they were unable to deal with their concerns directly.
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, both formally or informally.
- Staff told us that ward sisters investigated complaints, and gave them feedback about complaints in which they were involved.

- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- The surgical matron received all the complaints relevant to her unit. They would then speak directly with the staff member involved. A response would be sent to the complaints department and they would arrange for a response from the trust. Lessons from complaints were shared within the department.

Are surgery services well-led?

Good ●

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

Strategic plans were addressing capacity issues within the service. Some staff said they felt pressurised when patient admissions fluctuated. Senior managers were aware of the issues, and were monitoring the additional pressures.

The service held monthly clinical governance meetings, where quality issues such as complaints, incidents and audits were discussed. The service had quality improvement initiatives, which looked at, for example, the productivity of theatres. There were comprehensive risk registers for all surgical divisions. The division was aware of its problems, and addressing or escalating concerns where appropriate.

There was positive awareness amongst staff of the values and expectations for patient care across the trust. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service. Staff told us they felt there was effective and supportive team working across professional groups in the surgical service.

The trust held monthly care group engagement sessions for all staff, which included training updates. Staff were able to raise any concerns, or share an experience, within the surgical monthly clinics. Patients were engaged through feedback from the NHS Friends and Family Test. Innovation was encouraged from all staff members across all

disciplines. Junior doctors were involved in audits, with the results shared within the department. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

Vision and strategy for this service

- The trust's vision is to be trusted on quality, and the delivery of a service to the taxpayers, whilst providing excellent healthcare. The aim of the trust is to be trusted by staff, patients and the public, to provide the services that commissioners and the taxpayer can understand and afford, whilst developing better treatment for patients, and training healthcare professionals of the future.
- The trust's 2020 vision outlined how they would continue to build their reputation around six key 'defining' services, which are neurosciences, cardiovascular, gastrointestinal (GI) services, respiratory services, oncology, and women and children. Doctors and nurses would work alongside scientists as they deliver these services, creating fully integrated clinic-academic centres.
- The operational and strategic plan for surgery (2014-16) looked at the demand on theatres. The trust had commissioned two modular theatres, which were in service and had released two theatres' capacity to meet RTT plans and emergency pressures, as well as facilitating the theatre refurbishment programme. Senior management also said they wished to improve the discharge journey for patients, which would minimise re-admission risks.
- Staff were passionate about improving the service for patients to ensure they provided a quality service, and individual wards had developed local visions of care. Staff were able to describe how they had jointly involved the whole care team in their local plans.

Governance, risk management and quality measurement

- The service held monthly clinical governance meetings, where quality issues such as complaints, incidents and audits were discussed. Staff were able to identify incidents and how they were shared with others during team meetings. We observed feedback from root cause analysis meetings being disseminated to staff on duty.
- The service had quality improvement initiatives which looked at, for example, theatre productivity, better access for patients, and fracture liaison services.

- The division had quality dashboards for each service and ward area, and this showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- The trust had completed local as well as national audits, such as a regular audit to ensure that staff record keeping and accuracy were compliant with national standards.
- There were comprehensive risk registers for all surgical divisions, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the trust's risk register, where they were presented to the trust's executive committee and were regularly reviewed. One example identified delayed discharges out of recovery for the theatres and sterile services. The register identified the risk, the impact to the patient, and the controls, such as restricted operating during Winter pressures, and the identification of delays of more than an hour.
- The service held monthly clinical governance meetings, where quality issues such as complaints, incidents and audit was discussed and actions agreed in response to concerns.

Leadership of service

- Staff were aware of the head of nursing within the hospital, who they said was visible and approachable.
- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. Members of staff told us that the manager was visible and approachable.
- Staff within gastrointestinal, and trauma and orthopaedic wards commented that the matron often worked on the ward, and supported staff with the personal care of patients.
- During a focus group, medical staff said the chief executive was supportive of changes, and appeared caring and involved in staff welfare.
- Some staff said the leadership from the trust could be improved and felt their ideas did not always filter down to staff.
- Ward managers said they had access to leadership development courses, which were good, and they had protected training.

Culture within the service

Surgery

- The trust's values included putting patients first, working together as a team, and enveloping fresh thinking. Staff were aware of the values for their service.
- During a focus group, surgical staff said that there was a culture of quality improvement within the trust, with regular meetings between the medical director and junior doctors.
- Staff were passionate and driven to provide good care to patients, but felt that this could not always be given, due to the pressure of work. We saw staff spending time talking to a patient who was confused and distressed. We also saw staff being supportive to a relative of a patient within the respiratory ward.
- Staff we spoke with worked well together as a team, and said they were proud to work for the trust.
- Staff spoke positively about the lessons learnt from reporting incidents and raising concerns.

Public and staff engagement

- The trust held monthly care group engagement sessions for all staff. These sessions had a different focus every month, such as training updates.
- The surgical divisional leads held monthly clinics, whereby staff could raise any concern or share an experience.
- Patients were engaged through feedback from the NHS Friends and Family Test. Clinical governance meetings showed how patient experience data was reviewed and monitored. The cancer patient experience survey showed that 96% of patients said that they were always given privacy when being examined. The two areas which scored the least (65%) were: not given enough care from health or social services, and the family not given all the information needed to help care at home.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors were involved in audits and the results shared within the department.
- In the surgical admissions ward, staff were encouraged by improvements already made, to develop new ideas to make continuous improvement in the service provided. We observed that in all areas, staff had adopted national guidelines, and were aware of best practice for the conditions that their patients were admitted with.
- The health overview and scrutiny panel's cost improvement and quality report for January 2015 identified how the trust had promoted a greater focus on transforming change, by redesigning their model of care to either absorb growth in demand without the need for additional resources, or reduce costs, such as changing models of care to help patients recover more quickly and leave hospital earlier. This included enhanced recovery pathways, reduced medical length of stay, and working in partnership with community colleagues.
- The spinal service has undergone peer-review by the Royal College and planning was underway within the directorate to set up a new therapy and nurse-led specialist integrated 18 bed spinal ward, along with a spinal regional transfer unit for admissions.

Critical care

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

There are 88 critical care beds in Southampton General Hospital. The general intensive care unit (GICU) has 25 beds (8 level 2 and 17 level 3) and provides general intensive care treatment for elective, trauma and emergency patients. The cardiac intensive care unit (CICU) has 15 beds (2 level 2 and 13 level 3) and provides treatment for patients with cardiac problems, mainly those needing cardiac surgery. The neuro intensive care unit (NICU) has 13 beds (6 level 2 and 7 level 3) and provides treatment for patients with neurological conditions, mainly those needing neurosurgical procedures.

The surgical high dependency unit (SHDU) has 8 level 2 beds and treats patients undergoing complex surgical procedures. The respiratory high dependency unit has (RHDU) 7 level 2 beds and treats patients with acute or chronic respiratory failure; this can include weaning patients with tracheostomies from ventilators. The cardiac high dependency unit (CHDU) has a total of 20 critical care beds. The CHDU also had a six bedded Regional Transfer Unit (RTU) that was built to accommodate level 2 and 3 patients, but was commissioned and used for level 1 patients. The level 2 beds comprised of 14 cardiac surgical beds and six cardiology beds. There was provision to use the level 2 beds flexibly between cardiology and cardiac surgery in response to daily service requirements. The unit provided a Monday to Friday 'fast track' service in which cardiac surgical patients were admitted directly from theatres and ventilated for a short period of four to six hours post operatively.

An outreach service is provided by the critical care service. This provides a specialist nursing team to give advanced clinical advice or treatment if a patient's condition deteriorates on the general wards in the hospital. Their aim is to prevent patients having to be admitted to critical care beds.

The management structure of the hospital was divided into four divisions. GICU, CICU, NICU and the outreach service were managed under Division A. RHDU was managed under Division B and CHDU was managed under Division D.

Level 2 beds are for patients who need higher levels of care and more detailed observation and/or intervention. These patients may have a single failing organ system or require postoperative care. Level 3 beds are for patients who need advanced respiratory support, or basic respiratory support together with the further support of at least two organ systems. Level 3 includes complex patients needing support for multi-organ failure.

During two visits to the hospital, we visited all these intensive care and high dependency units. We talked with 12 patients, 11 relatives and 75 members of staff. These included nursing staff, student nurses, junior and senior doctors, physiotherapists, pharmacists, dieticians, housekeeping staff, technicians and managers. We observed care and treatment and looked at 15 care records. Before the inspection, we reviewed performance information from, and about, the hospital.

Critical care

Summary of findings

There were areas of good, outstanding and innovative practice in the critical care services. In the NICU an 'uncertainty, safety or stop' culture had been introduced to give permission for all staff – nursing, medical and allied healthcare professionals – to say, "I do not know how to do this and I need help." Also, band 2 healthcare assistants were completing patient profiles, so staff would be able to talk to the patients about topics they were interested in. In the GICU, the effective use of a research nurse released junior nurses to carry out research projects. A guidance pack for managing patients with challenging behaviours had been developed. Inventive staffing patterns in the CICU had released an extra member of staff to drive discharges and admissions with the aim of improving patient flow through the unit.

However, there were significant risks posed by the infrastructure and environment of the critical care services and staff were not assured that these were being addressed by senior divisional management. In the GICU, the environment was cramped, pillars obstructed the view of some patient bed areas, overhead hoists were not located in fully usable positions, and interruptions to the electrical power supply meant patients were without monitoring equipment for up to 2 minutes while equipment rebooted.

The treatment and care provided followed current evidence-based guidelines. The critical care services participated in national and local audits and there were good outcomes for patients. Staff had effective training, supervision and appraisal and there was good multidisciplinary working to ensure that patients' needs were met.

There were problems with the flow of patients through critical care areas which posed potential risks to the safety and welfare of patients. Patients were discharged to ward areas during the night, which national data and guidance have associated with increased mortality. Patients were remaining in critical care beds when they no longer needed them, which could result in mixed-sex breaches and lack of privacy and dignity. Patients admitted for elective surgery, and who needed planned

critical care beds, were remaining in theatre recovery areas for lengthy periods of time until critical care beds became available; this resulted in admissions to the units during night hours.

Patients were followed up when they were discharged from intensive care to a ward or their home; however, this was variable depending on the unit in which they had received their care and treatment. Nationally recommended follow-up clinics were funded for nurse led clinics. However, consultant support was not funded and was provided voluntarily.

The leadership teams of individual units were supportive and effective in mitigating risks. Staff reported a strong supportive working environment, which was led by matrons, senior sisters and lead clinicians. There was a vision to refurbish and expand the critical care services, but no agreed plans. Clinical strategies were based on continuing to achieve positive outcomes for patients. Governance processes were focused on risk and quality. However, for GICU there was a disconnect between the risks identified at unit level and those identified and understood by senior management. Staff felt they were not being listened to, and they were not confident that identified risks to patients were being addressed.

There was strong local leadership in each of the critical care units. There was a culture of mutual support and respect, with staff willing to help other units when they were short staffed. Innovative ideas and approaches to care were encouraged and supported; many of these enhanced patients' experiences in the units.

Critical care

Are critical care services safe?

Requires improvement 🟠

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

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Incidents

- Staff on all the critical care units knew how to use the trust's online incident reporting system. They knew they needed to report incidents such as patient falls, equipment errors, medicine errors, and admissions and discharges to and from the unit out of hours (that is, between the hours of 9.59pm and 7am). In the GICU, medical staff said that incidents were reported not by them but by nursing staff. Staff reported feedback about incident reports had been received.

Critical care

- In 2014, before the inspection, the trust had reported one serious incident in the critical care services that needed investigating. The service took appropriate action, which included a root cause analysis (RCA) of the incident and action to prevent similar occurrences.
- The trust reported that 38 significant incidents had occurred in critical care and theatres between 1 April 2013 and 31 March 2014. There was no breakdown of these incidents, so it was not possible to identify how many related to services provided in the critical care areas. However, the report highlighted good practice in the division that included a greater ownership of RCA, development of the divisional risk group and a focus on medication errors in critical care. The report also identified areas for improvement, which included an overarching review of divisional data to monitor and identify connecting trends from outcomes, patient experience and safety information and timely management of severe harm incident reports.
- Each area of the critical care services held mortality and morbidity meetings. (These are peer reviews and are a routine, structured forum for the open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care.) Records of the past three such meetings showed that the treatment and care practices for the patients were critically reviewed, and, when appropriate, proposed changes of practice identified.
- The divisional risk register detailed that patients who exhibited episodes of challenging behaviour as a result of their condition posed a risk to their own safety and that of staff and other patients. In response to this, a training package and guidelines for the management of such patients were developed by one of the nursing staff in the NICU. It was proposed that, once the guidelines were embedded into care practices in this unit, the package would be rolled out to the other critical care units and then to the rest of the hospital.
- A patient safety survey had been undertaken in theatres which had demonstrated improvement in staff raising concerns, being supported and promoting patient safety. The survey had indicated areas for improvements: as an increase in working hours and in the use of agency staff than was best for patient care.
- The anaesthesia and critical care research unit at the hospital had taken part in a 'survival after postoperative morbidity: a longitudinal observation cohort study'.

Duty of Candour

- The ethos of Duty of Candour was already embedded into the running of the critical care units.
- Staff understood their responsibilities with regard to the new Duty of Candour legislation. Information about this had been disseminated to staff through staff meetings and electronic communications rather than formal training. The legislation requires an organisation to disclose and investigate mistakes, and offer an apology if a mistake has resulted in a severe or moderate level of harm. Staff described a working environment in which any mistakes in a patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether or not there had been any harm. This ethos went beyond the Duty of Candour legislation.
- The cardiac intensive care unit (CICU) described an event when Duty of Candour processes had been followed. This involved a conversation with a patient about how their pressure sores had developed and what the unit had identified as root causes in an unavoidable incident. We saw evidence of the correspondence and records of the meeting with the patient in which the events were discussed, and we saw records that an apology had been given to the patient. This occurred before the Duty of Candour legislation had been implemented, indicating that the processes were already embedded into the running of the critical care units.

Safety thermometer

- NHS safety thermometer results for the year October 2013 to October 2014 showed that there had been no falls resulting in harm in any of the critical care services. However, all units with the exception of the surgical high dependency unit (SHDU) had reported patients who had developed pressure ulcers while receiving treatment. For the GICU there had been an increase in reported pressure ulcers in September 2014. For RHDU there had been an increase in reported pressure ulcers in November 2014.
- Safety thermometer results were displayed in the units. Some units used safety crosses to show the length of time since a patient had developed a pressure ulcer or a hospital-acquired infection, had had a fall. This meant that all staff, visitors and patients were informed of the unit's safety history.

Critical care

Cleanliness, infection control and hygiene

- Senior staff in the GICU described the unit as "slightly disabled to meet the infection control targets". This was because the environment's fixtures and fittings were old and worn, and cramped bed spaces made it difficult to access some areas for cleaning. Staff said they were mitigating the risk of cross infection by good hand hygiene practices.

- There were side rooms in all the critical care areas. Not all side rooms had lobbies and airflow systems to help prevent the spread of airborne organisms. As units were refurbished, isolation facilities would be updated to include such lobbies and systems.

- All critical care areas had nominated infection control link nurses to support staff with infection prevention practices.

- In all critical care areas, staff wore protective equipment such as gloves and aprons, and they disposed of them after completing a care task to reduce risks of cross-contamination. Specialised respiratory protective equipment was available and was also used by staff to minimise cross-contamination.

- All the critical care areas were visibly clean. 'I am clean' stickers were used to identify when equipment was last cleaned.

- The NHS staff survey for 2013 showed that 50% of staff said hand-washing materials were not always available. This was better than the national average of 60%. We saw that hand washing facilities were available throughout the critical care areas. Hand-wash basins were beside each bed space in the CICU, GICU and NICU. Hand hygiene gel was at each bed space and at strategic points throughout the units, including at their entrances. Hand-washing facilities were used by all staff.

- In all critical care areas, patients were screened on admission for MRSA, treated prophylactically and rescreened 5 days later. Records showed that there had been no unit-acquired MRSA in the period October 2013 to September 2014.

- There had been two incidents of reported Clostridium difficile infection in the critical care services – one in the GICU in October 2013 and one in the SHDU in January 2014. (Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.)

- The cleaning of ward areas was subcontracted to another company. Service level agreements detailed the cleaning schedules for each area, and who was responsible for carrying out the cleaning tasks. Bedside curtains and blinds were routinely changed every 4 months. Audits of the cleanliness of the environment were completed and displayed in each area.

- Data from the Intensive Care National Audit and Research Centre (ICNARC) showed that rates of unit-acquired infections were in line with those of other similar critical care units.

Environment and equipment

- The environment and infrastructure of the GICU posed risks to the safe care and treatment of patients. The unit had been developed and expanded into areas of the hospital that had not been designed for modern critical care services. The unit had been built before publication of the Health Building Notices HBN27, HBN57 and HBN0402, and therefore was not required to comply with the bed space requirements of those notices. However, the spacing around some bed spaces meant that access to the patient and associated equipment was cramped. Structural pillars blocked the view of some bed areas. Because of the difficulty in viewing all the bed areas, each had its own nursing station or desk area.

- The designated bariatric bed space was within the original build of the GICU, which meant it did not have to comply with the current guidance for critical care bed spaces. The bed space was deemed suitable because the ceiling height was able to accommodate a bariatric hoist. However the bed space was only 9m2 rather than 25.5m2 as specified in the current guidance for critical care bed spaces. It was unclear whether an assessment, other than the ceiling height, had been made of the suitability of this area for nursing and treating bariatric patients in a safe manner.

- The position of one bed space at one of the entrances to the unit meant that the nurse's station for that bed space had to be across a corridor. This meant that, if the nurse was writing in documents they had their back to the patient and were not able to observe them. When the bedside curtains were closed around the patient, this obstructed the corridor space. If a patient was being wheeled in or out of the unit, their bed dragged against the curtains.

Critical care

- The lack of space between beds meant it was difficult for all bed spaces to have reclining chairs for a patient's rehabilitation therapy. There is no national requirement about the availability and use of reclining chairs. However, the divisional risk register detailed there was a lack of storage space and availability on GICU, stating there were not enough reclining chairs to meet demand on the Unit. The risk register also detailed SHDU did not have any type of reclining chair capability or storage to keep them.

- It was reported by nursing and medical staff that the electrical supply to the GICU was frequently interrupted. Most equipment had a built-in battery that would run for several hours if the electrical supply failed. The monitoring equipment did not have battery back-up. It took monitors 2 minutes to reboot once the emergency generators had started, meaning that patients were without monitoring for 2 minutes, even if the power returned immediately. At the announced inspection in December 2014, we raised these concerns with the trust.

- When we visited for our unannounced inspection in January 2015, a weekly check and walk around the unit by the estates department had been initiated. This was to identify faults and concerns, and to make decisions about what actions should be taken to rectify faults. The member of staff from estates, who was doing the walk-around check, said that power cuts were commonplace in Southampton, indicating that this could be contributing to the interrupted power supply in the GICU.

- It was reported that there had been an incident when a member of staff had received a shock from electrical equipment. Investigation into this event by the estates team had found no electrical fault and they concluded that the event had been caused by local static electrical build-up, due to the nurse wearing thick-soled rubber footwear. No advice or action had been taken to prevent a reoccurrence of this incident.

- GICU medical staff expressed their concerns about the environment. They said the infrastructure was inadequate for current demands for patient care and for staff requirements. For example, at the time of our inspection, there was a lack of toilet and rest facilities for staff. The trust said a plan to replace staff rest facilities was due to be completed by March 2015. There was a lack of communal space for staff interactions. This meant the daily handover between 8am and 9am took place away from the unit, leaving no medical staff in the

unit during this time. If necessary, nursing staff could contact medical staff who would then leave the handover to attend to any patient needing immediate medical attention.

- The division risk register listed 23 risks for the critical care services. Five of these concerned the environment and equipment in the GICU. There was an entry for the risk associated with power failure in the GICU. This stated that the installation of an uninterruptable power supply would be completed by 31 December 2014 although this had not happened.

- Some staff reported a lack of hoists in the GICU, which was resulting in back injuries among members of staff. There was access to a total of nine hoists. Five of these were portable hoists which due to lack of storage space were stored off the unit. There were three overhead hoists located in side rooms that had recently been made available. However, the position of the tracks meant that these hoists could not be used to move patients while they were in bed. There was one overhead hoist in the main part of the GICU that was specifically for bariatric patients. However, this was out of use at the time of our main inspection in December 2014 and at the follow-up inspection in January 2015. The issue had been reported to the estates department but had not yet been resolved. The matron for the GICU confirmed that some staff had suffered back injuries; however, this was related to working in a cramped environment – for example, twisting to reach equipment and possible poor moving and handling techniques. Copies of incidents reported to RIDDOR showed that for the year December 2013 to December 2014 there had been two reportable incidents relating to back injuries acquired during the course of work. The matron confirmed that portable hoists were available, but stored in the adjoining CICU. Because of the risk of back injuries, the matron had arranged an occupational therapy assessment of the working environment and physiotherapists had advised all staff members about exercises to reduce the risk of injury while at work. A hover mattress, as detailed in the risk register, had been purchased to assist with safe transfers and moving of patients. Staff said they felt this was reducing the risk of back injuries.

- The limited space, lighting, obsolete call bell system, infection control risks with partitions and air filtration, and interrupted power supply had all been risk assessed. All were high risk and some mitigating

controls were in place, but the business case and funding issues were still being developed. However, the dates for the resolution of some of these were in early 2014.

- Out-of-hours radiography provision meant that patients in the NICU had to be transported out of the unit for computerised tomography (CT) scans. This required two lift journeys and transport along public corridors to another part of the hospital. The move posed a risk to the wellbeing of critically ill and unstable patients. There was a neurological radiography department with CT-scanning facilities on the same level as the NICU, but it was not staffed out of hours. To mitigate the risk, fundraising had made possible the purchase of a portable CT head scanner that would be located in the NICU. Staff from the main radiography department would have to carry out the CT scans, but it meant that patients would not have to be transported across the hospital. The matron said the portable scanner would be functioning by February 2015.

- The senior sister in the SHDU said the unit was listed on the divisional risk register because it was too small and not fit for purpose. The only entry on the risk register regarding SHDU environment was regarding a leaking air conditioning unit. There was no reference to lack of space on the unit. Incorporated into the environment risk for the GICU there was a note that there was no space in the SHDU to use stretch chairs for patients.

- SHDU staff said that the monitoring and infusion pumps were antiquated, different from those used on the GICU, and that the equipment used in the two units was incompatible. This resulted in temporary discontinuation of infusions and monitoring if a patient was transferred from one unit to the other. However, the trust said that this related to one monitor which could be sourced from the theatre suite if required and that all other equipment was compatible and used inter-changeably across the two units.

- Staff reported a good service from the hospital's equipment library. Equipment requested from the library was delivered promptly. The library was not staffed 7 days a week, but all staff had access to it out of hours so that equipment could be accessed.

- Processes were in place to ensure that equipment was maintained and safe to use. However, on the NICU,

records indicated that portable electronic testing on electrical equipment had not been completed annually, despite the matron confirming that electrical equipment was checked annually.

- Technicians were attached to each critical care unit; they provided support with the use of specialised equipment.

- Daily checks were completed of emergency equipment to ensure that it was in working order and ready for use.

Medicines

- Medicines were administered in line with the trust's management of medicines policy and the Nursing and Midwifery Council guidelines.

- In the NICU, medicines were stored in cupboards next to a patient's bedside. In other areas, medicine cupboards were used to store medicines. In some areas, including the cardiac high dependency unit (CHDU), GICU, CICU and NICU, the medicine cupboards were left unlocked. Risk assessments had been completed regarding this practice. It meant that there was instant access to medicines in urgent situations. A trust-wide audit and summary of drug cupboard security for the year 2014/ 2015 identified that these areas had completed risk assessments in order to have cupboards unlocked for instant access to urgent medicines. The same process had been completed for drug refrigerators.

- Controlled drugs were stored in line with trust policy and national guidance. Daily recorded stock checks were completed for all controlled drugs. Trust-wide audits for compliance with the trust policy for controlled drugs showed that CHDU was 100% compliant in November 2014. None of the other critical care areas were audited at that time.

- Refrigerator and room temperatures were monitored and appropriate actions taken when the refrigerator was outside the recommended temperature range.

- With the exception of the GICU, all medicine prescribing and administration were recorded electronically.

- Faulty air cooling systems in an area of CHDU meant that in the warmer months this section of the unit was very warm. During these times, regular testing of the medication storage area was completed to ensure that medicines were not being stored at a temperature that could reduce their effectiveness. Cooling systems were provided to ensure that medicines were stored at safe temperatures, and some medicines were stored in alternative areas. This issue was listed on the division's

risk register which detailed liaising was taking place with the estates team with the view of replacing the cooling unit. At the time of the inspection there was no date on the risk register as to when a replacement cooling system would be made available.

- There was a consultant pharmacist who oversaw the pharmacy service to the critical care areas. He led a team of five non-medical prescribing pharmacists. They attended ward rounds, reviewed and changed prescriptions, and briefed changes to medical and nursing staff.
- All critical care areas had access to microbiologists, who also attended ward rounds. This ensured appropriate use of antibiotics to treat infections.
- Medication errors were monitored and reported using the trust's incident reporting system. Appropriate action was taken in response to medication errors.

Records

- In all critical care areas, records were current, clearly laid out and provided a clear record of patients' care and treatment. Medical and nursing notes were kept separate and nursing notes were kept at the patient's bedside in all areas.
- Nursing records included risks to the patient of developing pressure ulcers, malnutrition, venous thromboembolism (blood clots) and specific risks that were associated with their clinical condition. When risks were identified, details were included in their care plan about the action needed to reduce the risk.
- There were clear records of decision-making processes and conversations with patients, relatives and other professionals such as physiotherapists, occupational therapists and social workers involved in the support of the patient.
- In all areas, care plans were clearly structured and completed to identify patients' needs and actions needed to meet those needs.
- Structured transfer forms were completed before patients were transferred from a critical care unit to a general ward or another hospital.
- Electronic patient records were due to be implemented across all the critical care services. Staff in the GICU were concerned about the impact the electronic recording devices would have on the environment, and whether

these would further cramp the space available. However, no assessment had been made of the impact the electronic recording equipment would have on the working environment.

Safeguarding

- All staff were required to complete training about safeguarding vulnerable adults and children as part of their mandatory training. Staff confirmed they had completed training about safeguarding adults, but not children.
- Records for nursing staff across the critical care areas at 24 November 2014 showed that all areas had achieved over 90% compliance with safeguarding adults training. However, this was lower for medical staff across the critical care services who had achieved a compliance rate of 81% with completing mandatory training about safeguarding adults.
- Compliance with competing child protection level 2 was poor with only nursing staff on the RHDU, the outreach team and NICU medical staff achieving over 80% compliance. Other areas achieved compliance in the ranges of 18 to 37%.
- However, staff demonstrated an understanding of safeguarding both adults and children and understood the process to be followed if there was a concern that an act of abuse may have occurred or that a patient was at risk of abuse.
- A challenging behaviour and safeguarding document had been produced by a sister on NICU. This was currently being piloted but gave staff structure and practical strategies to help assess patients and prevent or minimise distress to inpatients with challenging behaviours.

Mandatory training

- Staff reported that they were able to access electronic mandatory training online both at work and at home.
- Records provided by the trust showed that at 24 November 2014 there were shortfalls in achieving a minimum of 90% compliance with completing mandatory training for both nursing and medical staff in the critical care areas. Notably, all areas and staff groups were below the 90% target for compliance with practical moving and handling training, conflict resolution and child protection level 2. Four clinical areas, the SHDU, CICU, NICU and CHDU, and medical staff had not achieved 90% compliance with fire safety training. Four

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areas, the CICU, GICU, SHDU and CHDU, and medical staff had not achieved 90% compliance with training about the Mental Capacity Act 2008. The CICU and GICU had not achieved 90% compliance with medicines handling. Medical staff across the critical care services had failed to achieve 90% compliance with 24 of the 30 subjects deemed mandatory for them to complete. For some areas, the GICU, SHDU and RHDU, it was said to be unnecessary for staff to complete training about consent, while staff in the other areas required this training.

- Records of governance meetings outlined concerns that staff were being removed from mandatory training sessions in order to fill vacant shifts. The records reported that, when this occurred, it was being reported as an incident. These records also showed that training was being monitored and the division education lead was taking action with relevant clinical leads to support staff to complete their training.

Assessing and responding to patient risk

- Patient flow throughout the critical care units posed risks to patient safety. Nationally agreed standards (Intensive Care Society core standards for intensive care units 2013) state that discharges form critical care should occur between 7am and 9.59pm because discharges overnight have been historically associated with excess mortality. Critical care consultants said that 70% of the patient transfers from the GICU occurred out of hours. The trust reported that, for the period June to November 2014, there were 78 patients discharged from the GICU out of hours, 16 patients from the NICU, 37 from the CICU, 28 from the surgical HDU and 26 from the RHDU. There was no process for monitoring the reason for the out-of-hours discharges.

- Because of the delay in transferring patients out of the units, there were delays in admitting patients to the units. The trust reported that, for the period June to November 2014, admissions to the units out of hours were 286 patients for the GICU, 85 for the NICU, 38 for the CICU, 109 for the SHDU and 48 for the RHDU. There was no process for monitoring the reasons for the out-of-hours admissions or the outcomes for patients who were discharged out of hours.

- Risk assessments were completed for patients in all the critical care areas. These included assessments for the

risk of developing pressure ulcers, venous thromboembolism, malnutrition and falls. When a risk was identified, the action required to reduce or manage it was detailed.

- The MEWS system was used on the general wards to monitor patients' health and identify those whose health was deteriorating. Policies were in place that detailed when assistance should be sought from medical staff or the outreach team. Outreach nurses had patient group directions to administer oxygen, saline and salbutamol, and to carry out peripheral cannulation or arterial blood gas analysis. The outreach team said that there was a lack of consistency throughout the trust about when staff would contact them regarding deteriorating patients. Some staff were contacting them later than appropriate.

- The outreach team said there was a wide variety in the information that was provided to them when they were called to attend to a deteriorating patient. This could vary from "I need help now" to a brief overview of the patient's condition. They said they had even received referrals from patients themselves and their relatives. It was noted in documents the trust provided that it was introducing guidance about what information should be handed over to medical staff or the outreach team when referring deteriorating patients to them.

- The outreach team said that, if a patient needed admitting to a critical care bed, the procedure could be protracted. This was because the referral to critical care needed to be completed by a consultant to a consultant. Out of hours, some consultants did this by telephone referral; others would come to the hospital, which would take time. There were two outreach nurses on each shift, however this meant one nurse was occupied for a lengthy period of time resulting in reduced resources to attend to other deteriorating patients in the hospital.

- In the NICU, to reduce the risks associated with patients being treated and cared for by staff who might not have critical care or neuroscience experience, an innovative 'uncertainty, safety or stop' culture had been introduced to give permission for all staff nursing, medical and allied healthcare professionals to say, "I do not know how to do this and I need help." It was reported that all staff now took time to assess whether they could deliver aspects of care and treatment safely and, if they were unsure, they were confident to stop providing the care or treatment and ask for support and guidance.

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Nursing staffing

- Across all the critical care services, there were shortages in permanent members of staff. The trust risk register showed that a nursing staffing level and skill mix were not always matched to case mix demand and capacity, with one of the areas of concern being the critical care service. This risk had been entered on the risk register in July 2008. There were actions outlined to be taken to reduce the risk. These included maintaining recruitment, e-rostering all ward-based staff, using bank, agency and other temporary staff solutions, and holding weekly staffing and monthly trust staffing reviews.

- Vacancy rates as provided by the trust for nursing staff in critical care, covering the GICU, CICU, NICU, SHDU and the outreach team, stood at 7.65% in July 2014.

- Processes were in place across all critical care areas to ensure that staffing numbers meant that level 3 patients were nursed on a one-to-one ratio and level 2 patients on a two-to-one nurse ratio. This included the use of bank and agency nurses. Staff reported that they were fully supported by trust management to book agency nurses when necessary. A trust-wide and local induction checklist was completed for all agency nurses.

- Senior staff said that staff were sometimes taken out of mandatory training sessions to fill vacant shifts, and management days were sometimes cancelled so that staff could be deployed in the units to ensure that staffing levels were safe.

- On CHDU a telephone text system had been successfully introduced to give staff more flexibility to adjust their shifts and to be offered additional duties to backfill shortfalls at periods of reduced staffing, or high service needs. Staff said they liked this system as it allowed greater flexibility for home and work life balance and greater scope to alter their shifts at short notice. Staff were given the opportunity to opt out of this process if they desired. Utilising experienced CHDU staff in this way ensured safer clinical cover within the clinical environment.

- The core standards for intensive care units 2013 detail that a minimum of 50% of registered nursing staff should be in possession of a post-registration award in critical care nursing. Not all critical care areas (for example, the GICU and NICU) were able to meet that requirement because of staff turnover and access to critical care courses. To mitigate the risk for patients

being cared for by staff without appropriate skills, the Critical Care units provided a National competency based framework whereby level 1 competencies were achieved prior to commencing an in house critical care competency framework programme within 12-18 months. The same core standards detail that no more than 20% of staff on duty at any one time should be made up of agency staff. This standard was not consistently complied with.

- The core standards also detail the number of supernumerary clinical coordinators required to be on duty each shift, depending on the number of beds in a unit. The GICU had recently introduced a second supernumerary nurse in charge. . However, this meant that the unit still did not meet the guideline of three supernumerary nurses for a unit with 21–30 beds.

- The CICU had taken an inventive approach to their staffing patterns. The unit had identified that, because of the nature of the work, the dependency level of patients decreased in the morning. This had released an extra supernumerary member of staff for the morning to drive discharges and admissions with the aim of improving patient flow through the unit. A second supernumerary nurse coordinated the care of patients.

- The outreach team had two nurses available 24 hours a day. We were advised that the outreach nursing team had recently expanded by 80%. However, the lead nurse for the outreach team indicated that the resource was needed by the hospital more out of hours, which meant that the outreach nurse team on duty at night needed to increase.

- Each ward and unit displayed the planned staffing numbers against the actual staffing numbers on a particular day.

- The GICU had recently been expanded by 4 beds to 25 in total. Before the inspection, we were told the insufficient staff numbers and inadequate skill mix meant that the extra beds could not be made fully available. At the inspection in December 2014, the beds were being made available in stages so that new staff could be recruited to ensure safe staffing levels. The matron said she expected to have recruited sufficient staff to have all beds available in March 2015. However, on the last day of our inspection in December 2014, the unit was instructed to make an extra bed available. This compounded the unit's difficulties in making sure that no more than 20% of staff on duty at any one time were agency staff. When we visited for the follow-up

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inspection in January 2015, the GICU had 25 available beds. Because of the volume of work, the matron had not been able to stagger the opening of the new beds in line with the recruitment of staff.

Medical staffing

- In July 2014, the vacancy rate for consultant and senior medical staff across the critical care services stood at 7.03%. For junior medical staff it was 11.81%. Locum use was 3.96%.
- The divisional risk register showed that there was insufficient anaesthetic cover overnight in the NICU. This was confirmed in conversations with the matron and the consultant intensivist lead for the unit. At night the unit was covered by junior doctors who were not trained in anaesthetic skills for advanced airway management. To mitigate risks to patients, the day hours of consultant intensivists had been extended, and planned extubations occurred during day hours when there was appropriate emergency assistance available. The risk register stated that overnight an anaesthetist from F level theatres could usually attend an emergency. This did not meet the guidance of the core standards for intensive care units 2013.
- RHDU medical cover was provided by the respiratory medical team. This means that out-of-hours patients, who may be ventilator dependent to a degree, were attended to by physicians, most of whom did not have critical care experience or skills. To mitigate this risk, detailed written handover plans were prepared to give clear guidelines and instructions to the on-call medical staff regarding the management of each patient on the RHDU. In the SHDU, the medical cover was provided by GICU consultants. The consultant covering the SHDU changed daily. Nursing staff in the unit felt it would be more appropriate for continuity of patient care if the cover were to be in blocks of days rather than daily changes.
- It was reported in all units that the relationship between the intensivists and the general physicians and surgeons resulted in effective and appropriate care and treatment for patients.
- In all units it was reported that medical staff were contactable at all times. There were no reports of medical assistance not being available when required.

Major incident awareness and training

- Staff in all units were aware of the trust's major incident procedure and where to access the information if needed. They were aware of their individual roles and the leadership decision-making process for ensuring bed availability in the event of a major incident.
- Some staff had attended major incident training exercises, which had made them aware of the multi-agency approach to major incident management.

Are critical care services effective?

Good 🟢

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

The treatment and care provided followed current evidence-based guidelines. The critical care services participated in national and local audits in order to measure their effectiveness. Data from audits showed there were good outcomes for patients being treated in the critical care services.

Because of the large number of junior nurses and challenges associated with accessing post-registration critical care courses, nursing staff numbers did not meet the nationally recommended quota of 50% having a qualification in critical care nursing. To mitigate the risk of patients receiving ineffective care by staff who did not have the relevant qualifications and skills, all newly appointed nurses had to complete a locally developed and validated foundation course in critical care nursing. All areas had a dedicated nurse educator and all staff had to complete competencies in critical care nursing.

Multidisciplinary working was evident in all units. Patients were followed up when they were discharged from intensive care to the ward.

Staff had a good understanding of the Mental Capacity Act 2005 and how it related to their working practices. There was evidence that both formal and informal consent were obtained, and that best interest decision-making processes were taking place.

Evidence-based care and treatment

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- Critical care units' care practices followed current evidence-based guidance. Policies were accessible for staff and developed in line with national guidelines such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines for managing patients with a subarachnoid haemorrhage or a tracheostomy.
- Nationally recognised care bundles were followed; these included care bundles to reduce the risk of ventilator-acquired infections and central line infections and complications.
- The practice for discharging patients out of hours was not following evidenced-based guidance.
- National Institute for Health and Care Excellence (NICE) guidelines were followed, including the guidance for rehabilitation after critical illness. Patients had a rehabilitation assessment completed within 24 hours of admission to critical care.
- Critical care services took part in a number of national audits to measure the effectiveness of care and treatment provided, for example, the National Cardiac Arrest Audit and data submitted to the Intensive Care National Audit and Research Centre (ICNARC).
- Local audits included audits of the number of out-of-hours discharges from the critical care services, infection control practices and compliance with care bundles. Matrons identified follow-up on actions and monitored those areas with suboptimal performance.

Pain relief

- Patients' pain and response to pain relief were monitored as part of their routine observations. Patients and their relatives said their pain was well controlled.
- During ward rounds, the pain-relieving needs of each patient were discussed and their pain-relieving medication adjusted accordingly.
- A nurse specialist in pain control was contactable by telephone for advice, and would see a patient if asked.

Nutrition and hydration

- All patients had assessments completed about their nutritional and hydration needs, and their risk of malnutrition. Protocols and policies were in place regarding enteral and parental feeding practice.
- Patients had access to a dietician. Support was provided by dieticians who worked in specialised areas (for example, colorectal, intestinal failure and head injury). This led to difficulties for patients in the neuro intensive

care unit (NICU) in accessing dietetic support and advice if they did not have a head injury. Staff told us usually, if a dietician was in the unit advising and supporting patients with head injuries, they would provide guidance for patients with other conditions, although these might not be their specialised areas.
- The critical care pharmacists monitored the prescribing and making up of parental nutrition to ensure that it was safe for patients.
- Speech and language therapists were available to check that patients were safe to swallow, and to offer advice accordingly if patients did not have a safe swallow reflex. Instructions from speech and language therapists were recorded in patients' records and care plans.
- In the general intensive care unit (GICU), we observed catering staff visiting patients and asking them what they wanted for meals that day.

Patient outcomes

- Units displayed some outcome data at their entrances.
- The NICU reported that it had the best outcomes in the country for patients who had suffered a subarachnoid haemorrhage. The medical lead for the unit showed us evidence from a study that the unit had a higher than average throughput of patients with a subarachnoid haemorrhage and a low mortality rate, resulting in the best outcomes for these patients.
- Data from Risk Adjustment in Neuro Critical Care (RAIN) showed that outcomes for patients with head injuries treated in the NICU were better than the national average.
- Data from the Society for Cardiothoracic Surgery showed that, for the period April 2011 to March 2013, 3,621 cardiothoracic operations were carried out at the hospital with a mortality rate of 1.73%. This was below the national average mortality rate which was 2.5%. Audits completed by the cardiothoracic team indicated that, if these figures were updated to include operations up to March 2014, the mortality rates would reduce further to 1.44%.
- Data supplied to ICNARC showed that, despite routine out-of-hours discharges and constraint due the infrastructure of the GICU, there was no negative impact on outcomes for patients.
- An early mobilisation project by the physiotherapy team in the GICU, which included mobilising ventilated patients, was resulting in a reduced length of stay in the unit.

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- Local audits demonstrated compliance with care bundles (for example, for ventilated patients, urinary catheter care insertion and preventing surgical site infection). Action was taken when compliance was not met (for example, with peripheral intravenous cannula care in the GICU).

Competent staff

- Not all the critical care areas had achieved the recommended 50% of staff having a qualification in critical care. This was due to staff turnover and lack of availability of courses. To mitigate the risk of patients being cared for by staff who did not have the relevant skills, newly recruited nurses had to complete a locally developed and validated foundation course in critical care nursing.

- All nurses newly appointed to the critical care units had a 4 or 6 weeks' supernumerary induction programme depending on which unit they worked in. Staff confirmed that they remained supernumerary throughout this period. The supernumerary period could be extended if both the nurse and their mentor felt it was needed.

- All senior staff in the NICU had a qualification in neurological nursing.

- There were dedicated nurse educators in each unit who had responsibility for the development and training of staff.

- All units and ward areas required staff to complete competencies in critical care nursing. Some of the areas had locally developed competencies; other areas, including the intensive care units, followed competencies in line with nationally developed competencies. Each specialist area had colour coded the competencies to identify which ones were essential for their specialties. For example, in the cardiac intensive care unit (CICU), staff were required to complete competencies relating to cardiac care before completing competencies in neurological care.

- Nursing staff confirmed that they received annual appraisals. However, data supplied by the trust showed that for the critical care services the appraisal rate for nursing staff was not meeting the trust's target of 96%. The units' rates for compliance for nursing staff ranged from 87 to 97%.

- All nursing staff in all units commented positively about the training opportunities and education packages for staff development.

- Healthcare assistants had the opportunity to follow development packages to equip them with the skills to care for critically ill patients. In the GICU, CICU and NICU, some healthcare assistants with the relevant training provided care for level 3 patients who were ventilated and stable. They worked under the supervision of a registered nurse trained in critical care.

- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within intensive care rated their overall satisfaction with training as similar to that in other trusts. Handover was rated as an outlier above the national average, but study leave was an outlier below the national average. Junior medical staff said they were well supported. They received training on ward rounds and attended regular 2-hour teaching sessions weekly.

- Health Education Wessex graded the provision of medical training for postgraduates in the NICU as excellent.

- Allied healthcare professionals, including physiotherapists, occupational therapists and dieticians, confirmed that they received appraisals and completed mandatory training.

Multidisciplinary working

- There was evidence of multidisciplinary working in all critical care areas. This included physiotherapists, dieticians, occupational therapists and pharmacists.

- Dietetic support was provided by dieticians who were specialised (for example, colorectal, intestinal failure and head injury dieticians).

- In the respiratory high dependency unit (RHDU), the physiotherapy department was closely involved in the plans to wean patients from long-term ventilation.

- In all units, technicians supported staff with the management of equipment. In the NICU, the technicians provided support for all patient transfers, both between departments in the hospital or out of the hospital.

- Patients received follow-up once they were discharged from the critical care units. A team of specialist nurses (for example, head injury and subarachnoid haemorrhage nurses) followed up and supported patients and their families while they were in the NICU and when they were discharged from the NICU and the hospital.

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- The outreach nursing team followed up patients discharged from the GICU and surgical high dependency unit (SHDU) within the first 24 hours of their discharge, to provide support to ward staff, the patients and their family.
- Patients in the CICU were followed up by specialist cardiac nurses. The outreach team said they were rarely asked to review patients who had been discharged to the cardiac wards from the CICU.
- All units worked closely with the specialist nurse for organ donation, who was based in the NICU, to provide support for families whose relatives wished to donate organs in the event of their death.

Seven-day services

- The GICU, CICU and SHDU had consultant intensivist presence until 10pm and on site anaesthetic cover on site 24 hours a day, 7 days a week.
- The NICU did not have neuro intensivist cover on site at night. The divisional risk register detailed that medical staff covering NICU at night were not adequately trained to possess advanced airway management skills. The risk register detailed that to mitigate risks to patients planned extubations were avoided after 5pm and there was neuro intensivist presence in NICU for extended day time hours. Overnight staff on NICU had access to the on call anaesthetic team who were based in theatres in another area of the hospital. There had been no reported adverse events occurring due to the lack of neuro intensivist cover at night, but in response to identified risks the lead intensivist for the NICU was putting a case together for the recruitment of an additional intensivist so that the unit would be covered 24 hours, 7 days a week.
- Consultant cover for patients in the RHDU and cardiac high dependency unit (CHDU) was by their specialist consultant and the consultant on-call rota. For the RHDU, this meant that the respiratory on-call consultant might not have the skills needed for managing ventilated patients.
- A physiotherapy service was available 24 hours a day. A twilight service had been introduced across the critical care units to ensure that patients received physiotherapy in the evening. An on-call system was used out of hours and at weekends. Staff said there was no delay in obtaining physiotherapy support and treatment for patients out of hours and at weekends.

- There was a weekday pharmacy service from 9am to 5pm, with an extended dispensary service to 7pm. At weekends there was a dispensary service from 9am -1pm with a limited clinical pharmacy service provided to the medical unit (9am-3pm). The technical services unit provided a limited service on Saturday mornings 9am -1pm. On Bank Holidays the pharmacy provided a dispensary service from 9am-1pm. Out-of-hours there was an on-call pharmacist available.
- There were pathology services available 7 days a week, with out of hours being an on-call service.
- The outreach team provided a service 7 days a week.
- Imaging (x-ray) services were available out of hours with a core team of staff on site in the daytime and an on-call system at night. However, this had a negative impact on patients in the NICU. The x-ray department in the Wessex Neurological Centre was not staffed out of hours or at weekends. This meant that patients were transported across the hospital to the main x-ray department for essential computerised tomography (CT) scans.

Access to information

- All areas used electronic handover sheets to ensure that all staff had up-to-date information about patients in their unit.
- All staff had trust email accounts to access updates electronically.
- An electronic communication system was used to inform staff about issues relating to their local place of work as well as trust-wide issues.
- In the NICU, there was clear communication of patient information verbally on the ward round. There was a proforma for medical assessment that supported effective transmission of all relevant information on the round. At the same time, the consultant personally documented plans of treatment in patients' notes to ensure that all information was accurate.
- Discharge forms relevant to each area were completed before patients were transferred to other wards in the hospital or outside. Verbal handover also took place via telephone or face to face.
- The medical handover process for the RHDU to the night team involved the completion of a handover sheet that clearly detailed the plans of care for each patient. This reduced the risk associated with on-call medical staff without intensive care experience treating patients.

Critical care

Consent and Mental Capacity Act

- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes. Records showed that both formal and informal consent were sought. Training was provided by the trust regarding gaining consent. Records provided by the trust showed that for nursing staff there was 100% compliance with completing this training. However, medical staff were only 85% compliant, and records for the RHDU indicated that no medical staff in that unit had completed this training.
- In conversations with staff, they demonstrated an understanding of the Mental Capacity Act 2008. There was evidence in records of best interest decision-making processes being followed.

Are critical care services caring?

Good ●

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback from patients and their relatives showed that there was a caring and supportive, person-centred culture in all the critical care units. .

Patients and their relatives were active partners in their care. Staff were fully committed to working in partnership with people (for example, they had developed patient profiles (an account of a patients' interests, preferences and needs) and patient diaries to support communication and also be of benefit to patients who were unconscious, and would want to know who had cared for them and what had happened. People's emotional and social needs were valued by staff and embedded in their care and treatment.

Emotional support was available and provided. Staff were motivated to offer emotional care and support to both patients and their relatives (for example, they provided

follow-up clinics voluntarily in their own time). They also provided weekend services for the bereaved relatives to discuss the patient's care and treatment, respond to any concerns and provide emotional support.

Compassionate care

- Patients were very complimentary about the care and support they received. They were also positive about the staff approach to promoting their dignity.
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.
- We observed compassionate care from a member of the medical staff who arranged for a patient (who was clinically well enough) to be transferred to a district general hospital where a member of their family was being treated.
- Feedback from patients and their families in the form of thank-you cards was displayed in the units. Comments included, "I have a huge amount of gratitude for the service you provided me", "We appreciated what you did for my mum and to support us," "Thank you for taking such good care of x and for showing us great kindness and compassion" and "You treated us with the utmost sensitivity and respect".
- Thank-you cards and letters praised the units highly and spoke of "superb" and "excellent" care.
- A relative spoke about the support staff had provided, which included giving them drinks, food and a blanket at night to keep warm.
- Patients said they felt safe and secure with the care and treatment on the units.

Understanding and involvement of patients and those close to them

- Patients who we were able to have conversations with felt they were well informed and involved in the decision-making process regarding their treatment.
- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted during the night with any changes in the patient's condition and their wishes regarding this were respected.
- Both patients and their relatives commented that information was discussed in a manner they understood.
- We observed staff explaining to patients and their relatives the care and treatment that was being

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provided, in order to reduce any anxiety. Patients and relatives told us staff in the units was very supportive, and that explanations about equipment and what was happening helped to reduce their anxiety.

- In the general intensive care unit (GICU) and neuro intensive care unit (NICU) nursing staff kept patient diaries by their bedside outlining what events had taken place while the patients were ventilated (and therefore not conscious) or unconscious for other reasons. Relatives also made entries in the diaries. These helped patients fill in the missing gaps in their lives during their stay in the critical care units, specifically those who had been in a coma. Once they had recovered, the completed diary, which remained the property of the patient, was returned to them if desired.
- In the CICU, consultants arranged weekend meetings for bereaved families. Families were invited back to the unit to discuss their relative's treatment and death in order for them to better understand the patient's experience and the reason why they did not survive.

Emotional support

- As an innovation in the neuro intensive care unit (NICU) to support staff in providing personalised care, a band 2 healthcare assistant was completing patient profiles. This meant that staff would be able to engage the patients in topics they were interested in.
- The GICU and SDHU ran follow-up clinics where patients were invited to return so that their stay and care in the units could be explained to them to help their emotional recovery. These clinics were funded for nurse led services. However, consultant support was provided voluntarily. Consultant staff said this was because they had no funding and no allocated time in the working week to provide this service.
- In the cardiac intensive care unit (CICU), relatives of patients who had died were invited back, so that they could have a full explanation of what and why things happened. This was done because in times of distress relatives do not always clearly remember or understand what is being discussed with them.
- In the NICU, there were specialist nurses who followed up patients discharged from the unit. They were also involved in providing support to both the patient and their family during their stay in the NICU specialist nurses included head injury and subarachnoid haemorrhage nurses.

- There was no funding for psychological follow-up for patients admitted to the GICU. It was sometimes possible to access the paediatric psychologist for younger adults but there was no provision for psychological support post-discharge for older people.
- Staff said emotional support for patients and their families was available from the trust chaplaincy team who would provide support for patients of all faiths and those who did not have a faith.

Are critical care services responsive?

Requires improvement 🟠

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as requires improvement.

Ongoing patient flow issues in the hospital meant there were pressures to admit patients and the service could not respond appropriately to ensure that patients were discharged from the units in a timely manner.

Bed occupancy in the units for the period April 2014 to November 2014 was above the recommended rate of 70%. Data and professional guidance show that occupancy of over 80% is more likely to result in non-clinical transfers with their associated risks. The occupancy in all units generally ran between 90% and 100% with both the general intensive care unit (GICU) and cardiac high dependency unit (CHDU) frequently having occupancies of over 100%.

There was a higher number of patients discharged and admitted at night than in similar units. The Intensive Care Society core standards for intensive care units 2013 state that, historically, discharges from the critical care services overnight have been associated with excess mortality. However, there were regular out-of-hours discharges to the general wards. There was a higher number of discharges delayed over 4 hours compared with similar units. Although patients were well cared for, they were medically fit for discharge and a critical care unit was not the appropriate setting for them.

The patient flow issues also resulted in delayed admissions to the critical care units. Some patients undergoing elective

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surgery required planned critical care beds, but they remained in theatre recovery areas for lengthy periods of time until critical care beds became available, which resulted in admissions to the units during night hours.

There was a plan to develop and expand the critical care services. However, this plan was not established and there was no guarantee that funding would be made available. The planning for the recent development of the GICU that had resulted in the four extra beds had failed to ensure that overhead hoists were situated in positions that made them fully usable.

Follow-up clinics after discharge from hospital are recommended by the Intensive Care Society for patients' ongoing treatment and emotional and psychological support. These were not funded and patient follow-up varied depending on which unit they had received their care and treatment in. Some clinics were being run voluntarily by consultants and nursing staff.

Patients whose discharge from intensive care was delayed were sometimes cared for in areas that did not fully promote their privacy and dignity.

The critical care services were responsive to the individual needs of their patients. Staff understood how to manage complaints. Information was available for patients and relatives in the units and on the trust's website.

Service planning and delivery to meet the needs of local people

- The critical care units provided a service for patients undergoing elective and emergency cardiac and general surgery, and neurosurgery. The hospital was a regional major trauma centre and a regional neurological centre. This meant that the units treated critically injured patients. Most patients treated in the cardiac intensive care unit (CICU) were admitted for elective surgery. The neuro intensive care unit (NICU) also provided a service for planned treatments that required level 2 care, such as plasma exchange for some neurological conditions.

- The GICU had recently been expanded by four beds. The planning for this had originally been for more beds without considering the core standards for intensive care units 2013, which state that 50% of critical care beds should be in side rooms. The planning was amended to include three side rooms.

- Staff said there was minimal involvement of the nursing team in the initial planning and development of the new bed areas. This had resulted in the poor positioning of overhead hoists so they could not be used to help move patients while they were in bed.

- Before the inspection, we were told the insufficient staff numbers and inadequate skill mix meant that the extra beds could not be made fully available. At the inspection in December 2014, the beds were being made available in stages so that new staff could be recruited to ensure safe staffing levels. The matron said she expected to have recruited sufficient staff to have all beds available in March 2015. However, on the last day of our inspection in December 2014, the unit was instructed to make an extra bed available. This compounded the unit's difficulties in making sure that no more than 20% of staff on duty at any one time were agency staff. When we visited for the follow-up inspection in January 2015, the GICU had 25 available beds. Because of the volume of work, the matron had not been able to stagger the opening of the new beds in line with the recruitment of staff.

- As a consequence of the expanding GICU, storage, staff and visitor facilities were reduced.

- The divisional director of operations for critical care and anaesthetics said there was a 10-year strategy for the development of the critical care services to meet the needs of the local population and the needs of the hospital as a regional trauma centre. He had submitted a business plan in the financial year 2014/15 to increase the GICU from 25 to 40 beds and the CICU and NICU each from 15 to 18 beds. However, this plan had been withdrawn because of financial constraints. He planned to resubmit the plan for the 2015/16 financial year, but said there was no guarantee it would get approval.

- The divisional risk register outlined different proposed numbers for an increase in beds: four additional level 3 GICU beds becoming available shortly, two level 2 beds in the surgical high dependency unit (SHDU) at the beginning of January 2015 and one level 3 bed in the NICU.

- Planning of delivery of the service was coordinated at frequent bed meetings held during the day.

Access and flow

- Access and flow in an out of the units posed problems every day. The nationally agreed standards for critical care state that discharge from intensive care should

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occur within 4 hours of the decision that the patient no longer requires levels 2 or 3 care, and there should not be a non-clinical reason preventing such a move. Data dated 1 January 2014 to 31 March 2014 from the Intensive Care National Audit and Research Centre (ICNARC) showed that the GICU had more delayed discharges (more than 4 hours) than similar intensive care units. Data collected by the trust for ongoing audit of all the critical care services showed that this was a common problem across all units. Critical care consultants said that they had two to three patients a day who were stuck in the GICU, once discharged, because there were no ward beds available to give them.

- Delays in discharging from level 2 beds meant that patients, who were now at level 1, were treated in areas that were inappropriate for their needs. There was the risk that they would be nursed in a mixed-sex area that would not promote their privacy and dignity effectively. Toileting and washing facilities in critical care areas are not designed to meet the privacy and dignity needs of level 1 patients. When possible level 1 patients were cared for in side rooms to maintain their privacy and dignity. However, this was dependant on availability of side rooms as their priority use was for isolating patients to reduce risk of spread of infections. On 10 December 2014, it was reported that there were two patients in the GICU who did not need to be there.

- The nationally agreed standards state that patients should not be transferred between wards between the hours of 9.59pm and 7am. This is for safety reasons and because patients find it unpleasant to be moved from critical care areas to a general ward outside normal working hours. The prime reason for the delayed discharges was a lack of beds available on the general wards.

- During the week beginning 5 December 2014, 55 patients had surgery cancelled for non-clinical reasons because of bed capacity issues. It is unclear whether this had any impact on the critical care services. However, we were made aware that patients with cancer who required surgery often needed a level 2 or 3 bed afterwards and one could not always be secured, resulting in their surgery being cancelled.

- The SHDU reported delays in transferring its patients to ward beds. Delayed discharges in the hospital usually resulted in patients being discharged to the wards

between 11pm and midnight. This meant that patients were nursed in recovery areas that were not intended to provide care for a long time, and patients were admitted to the SHDU at night when there was a reduced number of staff on duty. On 9 December 2014, there were admissions from recovery at 9pm and 3am because of delayed discharges from the unit. Both these admissions were planned surgical admissions. On another date, records showed that a planned surgical patient was admitted to the recovery area at 3.15pm, but was not admitted to the SHDU until 11.30pm; they were seen by the doctor on call that night at 12.30am. Records did show that the patient had been reviewed three times in recovery by the anaesthetist and once by the surgeon. To reduce risks to patient's additional anaesthetic cover in recovery was provided from 5pm to 9pm when patients were delayed in recovery.

- A patient said they were unhappy with their prolonged stay in recovery because it was very noisy, but commented, "If there are no beds, what can you do?"

- Data collected by the trust showed that for the period April 2014 to November 2014 there had been 458 occurrences of out-of-hours discharges from the critical care units. (This included data for the GICU, CICU, NICU, SHDU and CHDU, but not the respiratory high dependency unit [RHDU].)

- The NICU, in line with national guidelines, accepted patients for emergency treatment regardless of whether it had a bed available at that time. Staff said that the unit was the only neurological unit in the region that was following these guidelines, which consequently had an adverse effect on patient flow through the unit.

- Patient flow for patients admitted to the NICU with spinal injuries was delayed because of the lack of spinal rehabilitation beds. At the time of the inspection, the unit did not audit delays for this group so did not have statistical evidence.

- For the period April 2014 to November 2014, bed occupancy across all units ran above 70%. This was above the Royal College of Anaesthetists' recommendation of 70%. Persistent occupancy of more than 70% suggests a unit is too small and occupancy of 80% or more is likely to result in non-clinical transfers, with associated risks. Bed occupancy in the units was generally 90 to 100%. The lowest occupancy was one record of 73% for the GICU in September 2014. Both the CICU and CHDU had bed occupancies of over 100% in most months.

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- The overwhelming reason for the high bed occupancy was delayed discharges from the unit because of the lack of general hospital beds. These delays meant that there were a significant number of patients receiving level 1 care in the critical care units. Data supplied by the trust showed that for the same period there were 2,520 level 1 patient days in the critical care units. There was no monitoring as to whether the delays in patient discharges to the general wards resulted in mixed-sex breaches.
- Patients received follow-up once they were discharged from the critical care units. A team of specialist nurses followed up and supported patients and their families when they were discharged home from the NICU.
- Follow-up of GICU and SDHU patients after discharge from hospital was carried out by the GICU consultants. There was no funding for this service so two GICU consultants ran it voluntarily in their own time. The core standards for intensive care units 2013 state that patients discharged from an intensive care unit should have access to an intensive care unit follow-up clinic if rehabilitation needs are identified. The clinic does not need to be at the same intensive care unit.

Meeting people's individual needs

- There were some issues regarding promoting and protecting patients' dignity. The need to transport NICU patients through the hospital for out-of-hours computerised tomography (CT) scans meant they travelled through public corridors that did not promote their privacy or dignity.
- Delays in discharge from level 2 beds meant that for level 1 patients there was the risk that they would be nursed in a mixed-sex area that did not effectively promote their privacy and dignity.
- Some patients undergoing cardiac surgery and being treated in the CICU and CHDU had a learning disability associated with their congenital cardiac condition. Staff spoke about reasonable adjustments being made to meet these patients' needs. These included nursing the patient in a side room if clinically appropriate, so that they could be supported by relatives or carers. Pre-assessment processes for elective patients meant their needs and required adjustments were known before they were admitted to the units.
- All staff knew there was a specialist learning disability nurse and team they could access for advice and

assistance when caring for patients with a learning disability. Staff said that, whenever possible, adjustments were made to meet the needs of all patients.
- A package had been developed to help staff to support patients who exhibited challenging behaviours as a result of their condition or illness, and to meet their individual needs.
- There was no funding for psychological follow-up for patients admitted to the GICU. It was sometimes possible to access the paediatric psychologist for younger adults but there was no provision for psychological support post discharge for older people.
- Staff reported there was 24-hour access to the translation service. They also enlisted their own staff to help whenever possible.
- Information was available in leaflet format and on noticeboards in each of the units. Information about the trust's critical care services was also available on its website. However, the information on the website was not easily accessible to people who had any difficulties with reading written literature. There was no way to enlarge the writing for people who had visual difficulties. There was no means of changing the background colour for people who had dyslexia. There was no way of translating text. This meant that some people might not be able to access the information fully.
- The environment in the NICU was not appropriate for discussing difficult news with relatives. There was one visitors' room with no separate area in which to have private conversations.
- In the NICU, it had been identified that staff were unsure about how to meet the needs of patients showing challenging behaviours. To address this, a guidance pack had been developed and was being trialled in the unit with the aim of cascading it to the rest of the critical care services and the general hospital.

Learning from complaints and concerns

- Staff understood the hospital's complaints policy and knew how to manage any complaints they received. They all said they would try to resolve any concerns or complaints that a patient might have before they escalated into formal complaints. Information about complaints processes were displayed in the ward and unit areas.
- Patients and relatives said they would voice concerns or complaints directly to the nurse in charge of the shift or

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the nurse caring for them. They were confident that concerns and complaints would be treated seriously and dealt with promptly. Some relatives told us they had raised some concerns that had been dealt with promptly and to their satisfaction.

- Records were kept in the units about any complaints received and resolved locally without being escalated into the trust's complaints procedure.

Are critical care services well-led?

Requires improvement ●

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as requires improvement

There was a vision to refurbish and expand the critical care services. However, there was no agreed plan for this expansion. Staff were aware of the vision but not confident that the trust had a plan or strategy for the development of the services.

Governance processes had a focus on risk and quality and there were critical reviews of the provision of the service. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. Local leaders ward managers, matrons and consultants were concerned about the pressures on the service and the impact on patient care and safety. However, these were not identified on risk registers and there was a lack of interim plans and senior management support to manage and mitigate risks.

Clinical strategies were based on continuing to achieve positive outcomes for patients in all the separate critical care services in the hospital. There was strong local leadership in each of the critical care units. Within the service there was a culture of support and respect for each other, with staff willing to help other units when they were short staffed.

Innovative ideas and approaches to care were encouraged and supported. Many of these were enhancing patients' experiences in the units.

Vision and strategy for this service

- There was a strategy for the development of the critical care services that involved the refurbishment or rebuild of the general intensive care unit (GICU). A capital prioritisation brief dated 24 October 2014 detailed the proposed spend for this development up to the year 2019. However, the plan to expand the service had not yet been approved. The divisional group manager said that it was not guaranteed that funding would be made available. There was no interim plan to deal with the current pressures imposed by the environment of the GICU.
- The matron for the GICU said that scoping meetings for planning the future development of the unit had been cancelled because of financial constraints. However, when we completed the inspection in January 2015, she said the meetings were being reinstated.
- Staff were aware that there was a vision to expand and refurbish the critical care services. However, they were not confident that the trust had a plan or strategy to meet this vision.
- Staff said the trust's vision and values resonated with care at a local level on wards and units. They saw 'putting patients first' as their primary value and told us they felt it was part of the culture of the trust.

Governance, risk management and quality measurement

- Critical care governance meetings were attended by matrons and clinicians from the GICU, cardiac intensive care unit (CICU), neuro intensive care unit (NICU) and surgical high dependency unit (SHDU). Staff and clinicians from the respiratory high dependency unit (RHDU) attended the respiratory medicine governance meetings and those from the cardiac high dependency unit (CHDU) attended the cardiothoracic governance meetings.
- Records of governance meetings showed that risks to the service, significant events both in critical care and in other areas of the hospital, finances for the trust and the critical care services, education, HR issues and clinical effectiveness were discussed at these meetings. There was detail about actions required and who would be responsible for them. However, staff said there was no protected time and no allocated paid time for them to attend such meetings such as the governance meetings.

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- Most units and wards had meetings where staff were updated on information from the hospital clinical governance meetings. This included information on complaints, incidents and audits. Some units found that, because of the number of staff employed and the workload, it was increasingly difficult to hold ward meetings that staff could attend. On all wards and units, the risk of staff not receiving information because they could not attend meetings, or meetings were not held, was mitigated by the use of newsletters, emails and discussion at handover periods and one-to-one meetings with staff. All staff said they were informed about issues relating to their unit, division and the trust as a whole.

- A practice of peer reviews had been implemented across the trust. These reviews asked questions about whether the ward or unit was welcoming, safe, caring and well organised. Records from peer reviews of the critical care units showed that areas identified as requiring improvements were acted upon.

- Units took part in national surveys to monitor the effectiveness of their service. Local auditing was completed. For the GICU, this included auditing the number of delayed discharges and the impact these had on bed occupancy, and auditing compliance of the use of care bundles.

- Patients and relatives were involved in the governance process by the canvassing of their views about their experiences with satisfaction surveys.

- The trust's corporate risk register had two items that related to the critical care services. The first concerned inadequate staffing and skill mix in the critical care areas. Actions to mitigate the risk and ongoing actions were detailed. The second regarded identifying deteriorating patients on the general wards. The register stated that SBAR was being rolled out. SBAR was 'Situation, Background, Assessment and Recommendation', a communication tool that is used in healthcare settings to convey accurate information about a patient's condition and would be used to convey information to the outreach team. At the time of the inspection, there was no evidence that SBAR was being used which was corroborated by the outreach team explaining they received varying degrees of information when a patient was referred to them. There

was nothing on the corporate risk register that related to the environmental issues in the GICU or of the pressures on the critical care services. These issues were detailed on the divisional risk register.

- When asked about the risks detailed on the register for the GICU, the divisional group management appeared unaware of what these were. Their response was that they planned to have a new purpose-built GICU, which would resolve some of the issues. When asked what was being done at the present time to minimise risks, they replied "nothing".

- Divisional risk registers included environmental and staffing issues in the GICU and NICU, and a lack of level 2 and 3 beds in the trust. The risk register stated that four levels 3 and 4 beds were coming on line in the GICU. We were made aware that these had not been fully implemented because of lack of staff. The risk register also detailed that there would be an additional two level 2 beds in the SHDU in January 2015 and a further one level 3 bed in the NICU. There was no timescale for the NICU level 3 bed. Staff on the SHDU did not indicate that they were aware of plans to have a further two level 2 beds.

Leadership of service

- Staff in all critical care areas spoke highly about and had confidence in their local leaders, (matrons, ward managers and lead consultants).

- Leadership training was available to equip staff with the skills to lead teams. Staff spoke positively about the training and how it supported them to develop their leadership skills.

- Staff felt communication from the chief executive officer was good. Emails were sent to staff weekly, updating them about what was happening in the trust. The chief executive officer was described as being "hands on", meeting with staff and patients.

- Most units and staff felt well supported by the senior management of the trust; there was an extremely approachable hierarchy.

- However, staff on the GICU felt their concerns about the infrastructure and capacity of the GICU were not being listened to by the trust. They felt the senior management of the hospital executive board and the divisional management were not taking into

consideration their views about risks to patients and staff safety due to capacity and infrastructure of the unit. They did not have any confidence that the trust was addressing these concerns.

Culture within the service

- Staff in all units spoke positively about the service they provided for patients. They said there was an open and transparent culture that focused on meeting patients' needs.
- Staff said they felt valued team members. They provided examples where local management had supported them with their professional and personal needs to enable them to work to their best ability.
- Staff worked together across the units and divisions to provide safe care for patients. This was demonstrated with staff from the CHDU working in the CICU despite the two units being in different management divisions. Each unit had processes to ensure that the same member of staff was not helping other units all the time. Staff worked well together and there was obvious respect for each other.
- In conversations, the NICU lead consultant demonstrated passion for efficiency in the unit. He discussed how this message was transmitted to staff by him and the matron, and commented that staff morale remained high despite the unit being short staffed.

Public and staff engagement

- Staff told us that staff meetings and handover sessions were used to keep them informed and involved in the running of the critical care services and the hospital.
- However, in the GICU, staff were not fully engaged with plans to refurbish or rebuild the unit. Staff knew there was talk and had been talk about having a new GICU, but they did not know whether or when this was going to happen. Some staff were disbelieving when told the changes would be made in the next 4 years.
- Patient and family feedback about the service provided was gathered by using satisfaction surveys. Changes in practice were introduced as a result of patient feedback. In the NICU, this included changing the position of the x-ray viewer from the foot of a patient's bed because patients reported that they thought medical staff were talking about them when they were viewing x-rays.
- Most units displayed the feedback from the NHS Friends and Family Test and satisfaction surveys, and outlined

the action they were taking to address any issues that had arisen from the results. These results were displayed in the form of graphs as well as narrative to describe issues and actions taken in response to issues.
- Because of the layout of the GICU, there was no obvious place to display the results of surveys.

Innovation, improvement and sustainability

- There were many innovative practices developed in the critical care services to support their improvement and sustainability.
- The local leadership on the GICU had identified that research nurses who spent time working on the unit were not included in the staffing numbers. This released junior nursing staff to complete their own large or small research projects. One example was looking at how the risk of accidental extubation related to the size of toothbrush used for mouth care.
- In the NICU an 'uncertainty, safety or stop' culture had been introduced. This was in response to the increased use of agency staff and staff working in that area who had not completed a neuroscience or critical care nursing course. The process was developed from the World Health Organization (WHO) surgical safety checklist and adapted for use on the wards. It gave permission for all staff nursing, medical and allied healthcare professionals to say, "I do not know how to do this and I need help."
- In the NICU, a band 2 healthcare assistant was completing patient profiles. This gave staff insight into a patient's likes, dislikes and interests, and enabled them to talk with the patient about subjects that interested them whether they were conscious or not.
- A guidance pack for managing patients demonstrating challenging behaviours had been developed by one of the nurses on the NICU.
- Fundraising meant a mobile computerised tomography (CT) head scanner had been bought and was going to be used from in the NICU from February 2015. This meant patients would not have to be transferred across the hospital for out-of-hours urgent scans, thereby increasing their safety and not depleting staff numbers in the unit.
- The patient workload had been assessed in the CICU. Because the service there was predominantly elective, this meant that in the morning patients had lower care needs than in the afternoon postoperatively. There was therefore more shared care in the morning (that is, one

nurse looking after two level 2 patients). The number of staff on duty had not been reduced to reflect patients' needs, but a member of the nursing team had been released from care duties to work as a bed coordinator, working with the cardiac bed manager to drive discharges from the unit to free up beds for patients returning from theatres later in the day. This meant that the nurse in charge was free to support staff and attend ward rounds without being distracted by managing patient discharges and coordinating bed flow.

- In the GICU, consultants followed up patients in their own time in order to provide a complete service.
- Records of governance meetings showed that the service was working within a cost improvement plan. However, they also showed that this plan was not being fully achieved, predominantly due to spending on medical and nursing staff that included locum and agency cover for vacant posts.

Services for children and young people

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Outstanding**	☆
Responsive	**Requires improvement**	🟠
Well-led	**Good**	🟢
Overall	**Good**	🟢

Information about the service

Southampton Children's Hospital, which is part of Southampton General Hospital, is a centre for specialist paediatric services in the south of England, providing acute specialist care for the local population in Southampton and a larger area, including the Isle of Wight and the Channel Islands. The hospital offers a wide range of diagnosis, treatment and support facilities for children and their parents. These include an allergy and immunology service, which offers information and diagnosis; a cardiac service, which treats heart disorders and defects; and a foetal medicine unit, which treats women with high-risk or problematic pregnancies. Other children's services include the Piam Brown ward for the treatment of child oncology and haematology; surgery including neurosurgery; orthopaedics; paediatric medicine; the paediatric intensive care unit (PICU); the day care ward; the paediatric assessment unit (PAU) and the neonatal intensive care unit (NNICU) and special care baby unit (SCBU) based at Princess Anne Hospital. There are 187 beds over 14 wards and units with an additional 11 beds at Bursledon House. Bursledon House provides support and care to manage children's physical, psychological, educational and social needs from the ages of 0–16. Staff at the unit use a structured programme of care and treatment in a non-medical setting.

We visited the E1 ocean ward, the cardiothoracic ward; the paediatric assessment unit; G2, the paediatric medical unit; the neurosurgical ward and high dependency unit; G4, the surgical and nephrology wards; G3, the orthopaedic ward;

Piam Brown and the teenager and young adults' oncology unit; the day care unit, John Atwell ward; the NNICU/SCBU; the PICU; the operating department; outpatients and Bursledon House.

We spoke with 3 play leaders and 2 teachers; the youth support worker and approximately 45 members of nursing staff including matrons, senior sisters/ward managers, sisters, specialist nurses, research nurses, educational leads, staff nurses and healthcare assistants. We spoke with 8 therapy staff including a physiotherapist, occupational therapist, and speech and language therapist, and in the region of 15 medical staff. We also spoke with 2 ward clerks, 2 housekeepers, 2 domestic staff, 1 technician, the head of clinical engineering, the operational manager for child health, and the governance and risk lead.

We spoke with 15 parents and 6 children/young people and reviewed 12 sets of records.

Services for children and young people

Summary of findings

Children, young people and their families were positive about the care and support they received. They told us they were kept informed and involved in making decisions. The service provided outstanding support to children, their parents and families; peer support and social events were promoted and encouraged for children who attended the hospital often, because of the nature of their illness and particularly in the oncology and neonatal units.

There were systems in place to ensure that children at risk of harm, or considered to be of concern, were identified and protected if seen in the hospital. Following a high-profile incident in the past year, safeguarding procedures had been reviewed and new procedures put in place to protect and monitor children who may leave the ward environment. Staff were aware of how to report incidents and this information was monitored and reviewed, and the learning shared. Staffing levels were monitored and openly displayed. Areas were staffed with enough workers with the skills required to care for children and young people. On occasions when staffing levels were not as planned, action was taken to maintain a safe environment.

Children's care was provided based on national guidelines and best practice. Staff were supported in their role, and development opportunities were available and accessible. There was good multidisciplinary team working. A 7-day service was established for medical staff and being developed for all areas including support services such as therapies and diagnostics.

The service was looking for ways to improve access and had extended services, for example, in orthopaedic care and for back pain. There were, however, problems with waiting times for some services (for example, spinal surgery) and children did not always have pre-admission assessment to prepare for surgery. The current environment and facilities needed to improve. There was a lack of bathrooms for children and young people needing extra support (for example, lifting aids), and there were cramped conditions in some ward areas such as Piam Brown. The environmental space had become too small for the services being delivered. This

was recognised by the trust and there were plans to start work that would enable the relocation and expansion of two wards. Additional work was dependent on the proposed new children's hospital that was now delayed because of funding problems. The new hospital was planned for 2020 .

Staff worked effectively in teams and were positive about the leadership of the service. The strategy for the service was encompassed in the new hospital. We did not see evidence of an overarching clinical strategy though individual services had service reviews and plans were being developed to manage service issues as they materialised. There was an established governance system to monitor risk and quality . Young people's opinions and input were actively sought through surveys and consultation, and their feedback was used to improve the service.

Services for children and young people

Are services for children and young people safe?

Good ●

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good.

There were effective procedures to support children and young people to have safe care. Ward areas and equipment were clean. There was an open reporting culture and learning from incidents was discussed and cascaded. Age-appropriate clinic equipment was available and maintained, although some basic equipment, such as cots, and specialist equipment was not always available. Medicines were appropriately managed. There were enough trained staff on duty to ensure that safe care was delivered.

There were secure access systems in place to promote safety. Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed although not all staff had completed the appropriate level of training. The trust had reflected on and learned from a high-profile safeguarding incident that had occurred in the past year. Staff were aware of their responsibilities if a major incident was declared, and this included the process to follow for a missing child. There were new procedures in place to monitor children who might leave the ward environment.

The environment was creating a challenge and the service was outgrowing the space it currently occupied. In some areas, this had an impact on the ability to meet the needs of all patients in a safe way (for example, the space in the 4-bed bay on the oncology ward was limited and would be detrimental in an emergency. The size of the nursery in the neonatal intensive care unit (NNICU) area was also found to be cramped and not in line with current guidance. Staff were working flexibly to ensure that, whenever possible, risks were managed.

A paediatric early warning score (PEWS) system was used to enable the early detection of any deterioration in a child's condition. Audit had identified that children were not always escalated appropriately for observation or the attention of senior nursing or medical staff. This was being monitored at ward level and actions taken when appropriate.

Incidents

- There was an established system for the reporting, review and learning from incidents. There was a reporting process to ensure that any significant events were escalated through the trust's internal reporting system. The child health care group risk manager reported to the children's governance steering group, which fed into the divisional governance group.

- There was a care group risk lead who monitored incidents. If an incident was considered to be significant, then a scoping exercise would be undertaken to establish the action to be taken and whether further escalation to trust level was required. For serious incidents, root cause analysis (RCA) was used to investigate what had happened and to look at what changes needed to be made to prevent a reoccurrence. The divisional governance manger and a consultant paediatrician had been trained to undertake RCA. Outcomes were discussed at morbidity and mortality meetings. Learning from one incident had resulted in a review and changes to manual handling training.

- The trust reported 334 serious incidents between March 2013 and September 2014. Ten of these related to the children's service. Eight related to cases of infection On three occasions, wards were closed to control isolation and reduce the likelihood of the spread of infection. Two incidents related to pressure ulcers and RCA was undertaken. Changes were made to records to ensure that pressure sore risk assessments were fully documented on admission, and turns or repositioning recorded for high-risk patients. A spot check of records showed that these were being completed.

- Staff were aware of how to report an incident using the electronic reporting system. Senior staff were informed of the outcome of any investigations into incidents and they had responsibility for cascading this to other staff.

- There was also a monthly staff newsletter called 'Child health risk and patient safety'. This informed staff of the number of incidents that had been reported by ward or unit; the number of incidents by incident type; and a further breakdown of medication incidents by incident

type. Key learning points were also shared (for example, a reminder to document allergies correctly on operating theatre records) as a result of there being two incidents when allergies had not been correctly recorded.

- On Ward E1 a review of incidents had led to a change in the way the treatment room was used, with no distraction being allowed when medicines were being prepared.
- There was an identified health and safety and risk lead with named link nurses on each ward. When patient safety alerts were received, they were cascaded to the link nurse and ward manager who had a responsibility to ensure that the alert was reviewed, any required action taken and a response made to the overall lead. After a recent alert relating to the safe monitoring of patients receiving an intravenous morphine infusion, a risk assessment had been conducted and a management plan agreed for children and young people receiving such an infusion.
- Each specialty held its own morbidity and mortality meetings. These meetings provided clinicians with the opportunity to discuss errors and adverse events in an open manner, review care standards and make changes if required. We reviewed three sets of minutes, one each from child health, paediatric orthopaedic and the paediatric intensive care unit (PICU). There were representatives from the multidisciplinary team, discussion took place around incidents and then clinical-based discussions were undertaken on identified cases. The records demonstrated that discussion included learning from events and actions required.

Duty of Candour

- Staff were able to describe the principle of Duty of Candour and senior staff talked about the importance of ensuring that there was a clear audit trail of the process and steps taken. Staff told us that, if something went wrong, the relatives would be spoken with and written to. Junior staff, however, did not describe this as Duty of Candour.
- In the NNICU and the special care baby unit (SCBU), information was displayed informing staff about the duty of candour.
- A general email had been circulated notifying staff of the change in legislation and the trust's responsibility under duty of candour. A discussion about the new requirements had also taken place at the quality and

education meeting in December 2014, and included the responsibility to hold a meeting with patients and parents in circumstances of moderate or severe harm, or risk of harm.

- Staff were being open and honest when something went wrong. One parent described how an incident had occurred and, once this had been identified, they were told and kept informed throughout the process, including having meetings with the lead consultant. They reported "lots of things had been put in place and that they were more than happy that everything had been done".

Cleanliness, infection control and hygiene

- From 1 April 2014 to 1 November 2014 there had been three reported cases of Clostridium difficile and one of MRSA in children's services.
- Infection prevention and control practices were monitored through internal audits and 'spot light reviews' and, if required, action plans were developed when any issues were identified. We reviewed 14 results for audits conducted over the past 8 months. Nine wards or departments had scored above the benchmark of 90% the other five ranged between 80 and 89%. For each audit, action plans had been developed. For example, in the NNICU, which scored 90%, some of the issues identified related to the cleaning of the non-nursery areas. There was an action plan to address those issues. In the paediatric assessment unit (PAU), which scored 80%, immediate action had been taken to remove items that been incorrectly stored, and all staff were provided with a supply of hand gel to ensure hand cleanliness.
- Ward areas were visibly clean. Items were labelled as ready for use once they had been cleaned. Store cupboards were sometimes cluttered with items stored on the floors, which is not ideal because air cannot circulate.
- Alcohol hand gel and hand-wash sinks were available in patient areas. Hand gel was available outside the wards, bays and side rooms to facilitate hand hygiene before entering and leaving patient areas. Though there were no hand wash sink in the corridors so it was not possible to physically wash your hands before entering or leaving a patient area. Personal protective equipment, such as aprons and gloves, were readily available, and staff were

observed using these to protect themselves and others and reduce the risk of cross infection. This equipment was available outside the room of any patient being nursed in isolation.

- There was a system in place to reduce the risk of infection from a large number of children having access to the same toys. The play leaders were responsible for ensuring that the toys were cleaned, and records were kept to indicate that this was done.

Environment and equipment

- Age-appropriate equipment was available although there was a shortage of cots. For example, one child, a planned admission, arrived on Ward E1 and a cot had not yet been found; and in the PAU a father had slept with his young child on a bed because a cot had not been available.
- Some equipment was specific to the ward areas (for example, the ventilators in the PICU) and some was shared and available from the equipment store, such as infusion pumps. There was a technician on the NNICU/ SCBU who had a role in maintaining the department's equipment.
- It was not clear how the equipment asset register was maintained. One ward manager told us they were sent a register annually, but it did not contain all the equipment and not all items had a maintenance contract. It was reported that an equipment review was being undertaken and that procurement of new equipment would follow.
- Senior ward staff were clear that any new clinical equipment purchased had to go through the trust's procurement system and had to be tested by the hospital engineer before it could be used. Play leaders were clear that they were responsible for notifying the engineers of any electronic equipment they bought or was donated to them. These measures helped to ensure that asset registers were kept current, and that all equipment was tested and maintained.
- The hospital engineer told us all trust equipment supplied under contract was maintained by the supplier and there was a team that maintained a database of trust equipment. Equipment was labelled to indicate when it was last tested, and we saw that it was maintained and tested according to the required time frames. Most equipment was labelled to indicate that portable appliance testing had been carried out to ensure it was fit to use.

- To help maintain a safe environment, access to areas where children were cared for was secure with swipe card and buzzer-controlled entry. There were concerns that, even though there was a dedicated children's operating theatre department with secure external access, this area was part of a larger department and there was no restrictions to access from inside the department. This had been identified by staff and ways to manage this were being investigated.
- The current environmental footprint or space for the children's services was presenting challenges for the trust. As the demands on the service had increased, it had not been possible for the capacity to be increased within the current space. This was demonstrated by the 4-bed bay in Piam Brown, which was too small and not compliant with the current recommended bed spacing. Staff were aware of this and actively worked to ensure that the patients admitted to the area were risk assessed before admission. This ensured that they were of a low acuity, which decreased the risk of an emergency occurring in this limited space.
- The actual cot space in the third nursery in the NNICU areas was found to be cramped and not in line with current guidance. The trust was aware of this and had plans to reconfigure the nurseries that would ensure that the required space was available.
- There were two hydrotherapy pools, one specifically designed for children with a shallow end and a deep end. Systems to call for help in an emergency were in place, as was emergency equipment.
- There was a therapy room for children in the physiotherapy department but this was small. There was no equipment such as parallel bars, treadmills and bikes in this room and therefore they had to use the large adult gym. To try and ensure a child's safety, children were always supervised and there were blocked sessions for children only on specific days. The provision of facilities was being discussed as part of the development plans for the children's hospital.
- In case of an emergency, there were emergency trolleys in each area. These contained a standardised set of equipment. Random checks were undertaken by the resuscitation team when the sealed trolleys were opened and the full contents, including expiry dates, were checked. Full checks were also undertaken when an emergency occurred. Daily checks were completed by the ward staff.

Services for children and young people

- The risk register identified that specialist laparoscopic and colonoscope equipment for children under 7 years was unavailable. These risks were being managed in that procedures were not done if there was the potential for harm, but there could be delays in treatment for children. Business cases were being developed.

Medicines

- In the 12 months from April 2013 to March 2014, there were 240 medication errors reported; between April 2014 and September 2014 there had been 155. None of these were classified as severe.
- The number of medication incidents was being monitored and minutes of meetings showed that any issues were discussed and actions agreed. This had included the introduction of a training and assessment programme for junior doctors to complete before prescribing medication for children.
- Medicines including controlled drugs were securely stored, and storage temperatures were monitored to ensure that they were stored within the correct temperature range.
- There was an electronic prescribing system; allergies were recorded on this system and in paper records.
- Oxygen was generally piped to patient areas and where there were cylinders (for example, on emergency trolleys) they were correctly stored; there was an online system to request replacement cylinders.
- In the high dependency unit, the area where medication was prepared was small and close to the desk were staff gathered, which could be a distraction.

Records

- Records were found to be legible, well completed and signed, dated and timed by the person making the entry, thereby ensuring that a contemporaneous record was maintained.
- Patient records completed by nursing staff were found to be to a high standard and included completed risk assessments and care plans.

Safeguarding

- The trust lead for safeguarding was the director of nursing and organisational development. The trust had two safeguarding committees: one for adults and one for children. The safeguarding children's committee was chaired by the director of nursing. Both committees reported to the trust's quality governance steering group. Membership included external stakeholders as well as representatives from each of the hospital's operational divisions. A representative from each committee attended the local authority's Local Safeguarding Children Board to ensure effective communication on shared agendas.
- Information provided by the trust indicated that there was an overall child protection training completion rate of 80%. For Division C, of which the children's service was part, the completion rate for nurses and midwives for level 3 training was 71%.
- There was some confusion over the level 3 training. A new e-learning package had been launched; staff were aware of this and the need to access and complete the training. However, the fact that they needed to attend a face-to-face training every 3 years was not generally recognised.
- Staff reported that they had attended safeguarding training and were able to explain what their responsibilities would be. Staff were aware of the hospital's safeguarding team and knew how to contact them.
- There was a safeguarding assessment section on the patient record form. The parent or guardian was invited to complete this section of the form. The section facilitated the capturing of information relevant to the child's safety and wellbeing, including who had legal access, as well as living conditions and environment.
- The trust had cooperated with others to review an incident that had occurred in the past year. Policies and procedures had been reviewed and the learning was being cascaded. This included raising the alert, the initial action to take if a child was considered to be missing, and new procedures for monitoring children who left the ward environment.

Mandatory training

- Statutory and mandatory training included aseptic non-touch techniques; blood transfusion; child protection levels 1 , 2 and 3; clinical record keeping; complaints handling; conflict resolution; consent; customer care; equality and diversity; bullying and harassment; fire safety; governance and risk; hand hygiene; health and safety; incident reporting; infection control; information governance; medicine handling; mental capacity; moving and handling; patient falls; resuscitation; and safeguarding adults. The trust target for the completion of the above training was 95%.

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- Training figures provided by the trust for October 2014 showed completion rates varied across staff groups. The figures were red/amber/green (RAG)- rated to indicate the compliance level, with red below 60% of compliant staff, amber 60 to 89%, and green 90% and above. For nursing staff across division C, of which child health was part, the training figures were variable. Most training was rated amber, although moving and handling was only 53% and consent only 54%. Infection control, hand hygiene, incident reporting, governance and risk, and bullying and harassment were over 90%.
- The training figures for medical staff were also variable; most were rated amber. Moving and handling was low at 37%; blood transfusion was 100%.
- The practical manual handling completion rates were RAG-rated red; this had been acknowledged by the trust, trainers had been trained and practical training was being rolled out.
- Staff were aware of the requirement to complete their mandatory training and all senior staff were able to monitor completion rates. Completion rates were discussed at one-to-one supervision and displayed on wards. New staff were allocated time during their induction to complete mandatory training.

Assessing and responding to patient risk

- The PEWS system was used for the early detection of any deterioration in a child's condition based on observations. If a child's clinical condition is deteriorating, the 'score' for the observations will (usually) increase, and so a higher or increasing score gives an early indication that intervention may be required. Early intervention can 'fix' problems, avoid the need to transfer a child to a higher level of care, and thus avoid or reduce harm. The hospital monitored the use of the PEWS system. Data from 2013/14 demonstrated that it was being used but, when a child had an increased score, appropriate actions were not always taken. For example, observation were not increased or the nurse in charge or doctor were not informed. The PEW scores were being monitored by the wards. In one set of notes we reviewed, we saw that a medical practitioner had been called to see a young person when there had been a change in their PEW score. They had been moved to a high observation area and their monitoring increased overnight.
- There was a children's outreach team that could be called to review a child and that would review any

children discharged from intensive care. Staff reported this to be an effective and efficient service. We were told that staff from the team actively supported and guided other staff through review and decision-making processes; this helped staff with their own development, as well as ensuring that any child who was deteriorating was reviewed in a timely manner.
- The National Patient Safety Agency issued a patient safety alert in 2011 on checking for pregnancy before surgery. There was a trust policy to ensure that women of child-bearing age were not pregnant before surgery or interventions. The documentation had a section with questions for nurses to ask; nursing staff told that this was undertaken sensitively and without parents being present. This was confirmed by the review of two sets of records for young women.
- All children were weighed and their height measured on admission; this helped medical staff to ensure that the correct treatment, including medication, was provided.
- Risk assessments were completed on admission and reviewed during the admission period. The information from these assessments was used to inform the plan of care. Assessments included pressure sore risk assessment, handling and mobility, and daily skin assessment.
- When a child had a cannula (small tube inserted into the vein for the infusion of fluids and administration of medication) in place, the site was monitored to ensure that it was still fit to be used; this included an assessment of the position of the cannula and the skin surrounding it to ensure that it was still healthy.
- There was documentary evidence of the World Health Organization (WHO) checklist being used and this and the 'five steps to safer surgery' procedures were observed in practice in the operating department. The hospital had provided audit information from January 2013 and this had confirmed that there was, overall, 100% compliance with this procedure. There was an action plan for safer surgery that indicated the need for 6-monthly audits, which we did not observe.

Nursing staffing

- The hospital monitored and risk-assessed staffing levels daily to fill any gaps and ensure that safe staffing levels were maintained. Planned and actual nursing staffing levels were clearly displayed on status boards on the wards. There was no nationally agreed safer nursing tool for children's inpatient wards. However the Royal

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College of Nursing guidance 'Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers 2013' recommends a minimum of 70 to 30% registered to unregistered staff (although the precise ratio will vary throughout clinical areas); a minimum of two registered children's nurses at all times in all inpatient and day care areas; the shift supervisor in each clinical area to be supernumerary to ensure effective management, training and supervision of staff; and 70% of nurses to have the specific training required for the specialty (for example, children's intensive care).

- Reports provided by the hospital detailed planned staffing hours for each ward and compared those figures with the hours actually worked in order to calculate fill percentages. The numbers were monitored for day and night. For the month of September 2014, staffing levels on the children's high dependency unit and the critical care unit were maintained. For two of the wards the percentage of nursing staff were below the expected level. To maintain a safe level of staffing, staff had been flexible and moved from other areas, or the number of beds had been reduced. On the neonatal unit, when staffing levels fell below the required level to 73% registered and 85.5% unregistered in the day, and 77.6% registered and 82.7% unregistered at night, the number of cots was reduced.

- On the wards we visited and the rotas we reviewed, there were at least two registered children's nurses on each shift and shift leaders were supernumerary. We reviewed the nursing roster for E1 and found that the required staffing levels had been maintained for the week. Staff in Piam Brown, the day care unit, the medical unit, the paediatric assessment unit, the high dependency unit and the neurosurgical ward all reported that they had enough staff.

- In the NNICU, 52% of clinical nurses held a specialty-specific qualification with nine additional staff members undertaking an appropriate course. On average (for the month of November 2014), there were 16 nurses on a day shift; 76% of these were registered nurses and 42% of these held the additional qualification. There were 15 nurses on a night shift; 69% of these were registered nurses with 44% had a qualification relevant to the specialty. This was below

the Royal College of Nursing's recommended level of 70%. However, this had been acknowledged, recruitment was ongoing and there was a structured development plan for new staff.

- On the PICU, 55 whole-time equivalent staff had an additional qualification in paediatric critical care. Fifty per cent of staff per critical care shift held the additional qualification. This was below the Royal College of Nursing's recommended level of 70%. However, this had been acknowledged, recruitment was ongoing and there was a structured development plan for new staff. The nursing establishment for the unit was calculated on 7.1 staff per bed. The unit was open to 13 beds with plans to increase to 14. The nursing establishment was 99.83 band 7, 6, 5 and 4 staff with a 17.66% vacancy rate. Part-time staff worked extra hours and other staff worked overtime to ensure that the unit was adequately staffed. The number of actual hours worked was monitored by the electronic rostering system to ensure that excessive hours were not worked.

- The service had identified an insufficient number of specialist cardiac nurses: there were only two in Southampton, which was the lowest number nationally for similar trusts. The nurses were working as part of a network with Oxford to increase resources and develop a business case.

- Handovers were structured to ensure continued patient safety. Written information was supported by verbal handover from colleagues. Handovers took place in the staff room and were confidential.

- Since April 2014, staff sickness levels on the children's wards had been slightly above the expected percentage of 3.6% at 3.7%. For the neonatal unit, it was 3.6% against a target of 3.6%.

- For the month of August, 3.92% of staff had been agency or bank. Over the previous 12 months, this had ranged from 2.6 to 4.16%.

- Over the past 12 months, there had been a turnover rate of 4.4%. The trust had a vacancy rate of 6.56%.

Medical staffing

- Over the past 12 months there had been a turnover rate of 2.8%. The trust had a vacancy rate of 5.43% for consultants and senior staff, and 6.7% for junior staff. The amount of locum use was low and had ranged between 0.9% and 1.7%. However, neither consultants nor junior staff had reported problems with covering rotas or shifts.

Services for children and young people

- The trust had a total of 71.2 whole-time equivalent consultants working directly as part of a child healthcare group. These were spilt between two sites: Southampton General Hospital where the children's hospital was located where 62.8 were based, and Princess Anne Hospital where the NNICU/SCBU was located where 8.5 were based. In addition to these consultants, approximately 30 other consultants cared for children and young people. These included cardiothoracic surgeons and ear, nose and throat (ENT) surgeons, because there were not enough of them to create a dedicated roster for the children's service.
- The paediatricians provided a 24-hour service and it was this team that provided the first on-call response out of hours. This would ensure that medical staff with specific knowledge of the needs of children would respond.
- We observed four handovers during the daytime and evenings and found them all to be efficient and effective with an aim to ensure patient safety. The paediatric medical team met and discussed all patients. This was observed and reported to be a thorough, speedy and effective handover. The team would then move to the PAU for a further handover of patients either on the unit or expected to attend; this was led by the consultant who had overseen the service during the day. On the NNICU, there was a consultant-led handover that took place before the ward round. This was found to be very good. All patients were discussed and any outstanding task or results flagged for follow-up with responsibilities being confirmed at the end of the meeting. There was a multidisciplinary ward round on the PICU; this was found to be informative with contributions from each discipline. There was a discussion about each child, which included the current situation and forward planning.

Major incident awareness and training

- There were established arrangements in place with agreed actions for staff to take if a major incident was declared. In general, staff reported that they had not received any major incident training; however, information was available in the ward areas. Staff reported that, if an incident occurred, they would be informed and a bed status check conducted along with patient reviews to establish if any patients could be moved or discharged. This was in line with the written information available. The bed manager or bleep holder for the care group would take the lead in ensuring that the required information was gathered and the required action taken. Their office was the dedicated muster point for child health.
- Staff in the children's outpatient department were aware that, if an incident occurred, then clinics may be stopped and the area used as part of the emergency department.
- There had been a recent incident in the PICU when it had been necessary to evacuate the area. This had been safely and effectively achieved in 15 minutes.
- The trust had a high-profile safeguarding incident last year. It had undertaken an independent investigation into the issues and action taken. A missing child's policy was under development and awaiting ratification. The key components of the policy had been introduced. These included a flowchart of the action to take if a child was missing, and procedures to assess and monitor children who may leave the ward environment. We saw written evidence that this had been successfully implemented when a child went missing and was located within minutes in the main hospital corridor. The bed manager was clear about their responsibilities and the action to take if such an incident occurred.

Are services for children and young people effective?

Good ●

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

National Institute for Health and Care Excellence (NICE) guidance was being used and practice against these guidelines was being monitored and reviewed. Care bundles had been developed to support practice. Pain was assessed promptly and staff used age-appropriate tools. Staff were supported in providing effective pain relief by a dedicated children's pain team.

Staff were supported in their role through appraisals and supervision. There were structured development programmes to ensure they had the skills and knowledge

required to undertake their role. There were, however, areas for development in junior doctor training roles. Multidisciplinary working was evident across the care group. The trust had implemented a 'Ready, Steady, Go' initiative to support young people through the transition from children to adult services. A 7-day service was being developed and established for medical staff with consultant support, particularly paediatrician support available 24 hours a day. Children and young people's, or their parents', consent to treatment was obtained appropriately.

Evidence-based care and treatment

- There was a planned approach to monitoring compliance with the NICE guidance. Reports on compliance were reviewed and monitored through the Child Health Clinical Effectiveness Steering Group. This reported to the Quality Governance Steering Group, which in turn reported to the Clinical Effectiveness/ Outcomes Steering Group.

- Of the 47 NICE guidelines that had been identified as applicable to the children and young people's service, two had action plans in place to make them compliant; a further two had passed their review date and these were being followed up. On the day care unit, there was a clear protocol for the infusion of infliximab and allergy testing. Both were was said to be in line with current guidance but there were no references to support this.

- On Piam Brown, the children's oncology ward, staff undertook self-assessment against the NICE guidance 'Improving outcomes in children and young people with cancer'. The assessments for 2013/14 showed compliance with the guideline with the exception of the lack of a dedicated multidisciplinary team (MDT) coordinator. This meant that outcomes decisions were still written in paper format. A business case for an MDT coordinator had been developed and was awaiting approval. Templates were also being developed so that the MDT outcomes could be recorded electronically.

- There were a variety of ways that adherence to policies were monitored (for example, general observation of adherence to the uniform policy, as well as audits and surveillance). The aseptic non-touch technique was monitored through observation, a record was kept and then the results were analysed and shared. Any concern with practice would be taken up with the individual concerned.

- Following an in-depth review into why the children's service was failing the MRSA audit, it was established that while the care was being delivered it was not being recorded as per policy. A care bundle for the prevention and management of MRSA had been introduced. Walkarounds twice a week and audits were now conducted and doctors received specific training, which included what the signs on the cubicle doors meant, to ensure that they understood the infection control precautions to take.

- The audit plan for the child health care group included participation in 13 national audits. There was an audit programme that included both medical and nursing audits. The use of the PEWS system, aseptic non-touch technique, pain management and infection control practices, for example, were monitored through audit and good compliance was demonstrated.

Pain relief

- Three different pain assessment tools were being used to assess and monitor children and young people's pain. These were smiley faces, a linear scale of 0–10, and the Face, Legs, Activity, Cry, Consolability (FLACC) scale, a measurement used to assess pain for children between the ages of 2 months and 7 years, or individuals who were unable to communicate their pain. The scale is scored in a range of 0–10 with 0 representing no pain. It has five criteria, each of which is assigned a score of 0, 1 or 2. A review of records showed that these tools were being used to assess pain. The children we spoke with said they were asked about their pain, and parents felt that their child's pain was controlled.

- There was a children's pain management team. This was available Monday to Friday, 7am to 7.30pm. Additional support and advice were available from the paediatric anaesthetist. Protocols were based on evidence and covered the use of epidural pain relief, local infiltration, use of patient-controlled pain relief and infusions. Staff spoke highly of the pain team and reported that it provided a good service.

- The pain management team visited the wards daily and would also visit if asked to do so. It was supported by link nurses on the wards who received updates and training to help promote good pain control for children.

- The play leaders worked with children using a pain pump to ensure that they understood the use and purpose of the pump.

Services for children and young people

- The palliative care team had a role in pain management for children and young people with cancer and/or requiring palliative care. For these patients, support out of hours was available from the children's hospice.

Nutrition and hydration

- A speech and language therapist supported mothers who were breastfeeding babies in the neonatal unit.
- In the neonatal intensive care unit (NNICU) and the special care baby unit (SCBU), mothers were supported to express breast milk for their baby. They were given the necessary equipment and there was a dedicated private room for them to use. Fridges and freezers were provided for the storage of the expressed breast milk.
- There were two dedicated milk kitchens, with dedicated staff, where special feeds for babies were prepared. On the general ward areas, the kitchens had fridges dedicated to the storage of milk feeds. This meant that they could be stored correctly and be accessible when required.
- There was guidance on the management of nasogastric tube feeds, which included confirming the position of the tube, before feeding, using litmus paper. This was in line with current guidance.
- There was a 'rolling' menu, which meant that for some long-term patients the food became repetitive. Young people told us that to overcome this they were able to have food brought in. The teenagers and young adults on the oncology unit had been out to eat and had been able to order pizzas in.
- Special diets were catered for with menus available for patients with food allergies and intolerances, as well as cultural and religious needs.
- Advice and support were available from a nutritional team.

Patient outcomes

- The national peer review programme (September 2014) identified the paediatric diabetes service at the hospital as a high-performing team that was providing a good-quality service and was 87% compliant with the multidisciplinary team measures.
- The paediatric intensive care unit (PICU) admitted 1,000 patients a year. Almost half of the admissions were planned, following cardiac, general or neurosurgery. Between April 2013 and March 2014 the PICU, had 20 unplanned readmissions to the unit within 48 hours of

discharge. On average, this was two a month or 2.13% of the overall discharges from the unit, which was similar to the national picture. No elective operations had been cancelled due to the PICU service being unavailable.
- The trust participated in the extracorporeal life support register as a centre providing extracorporeal membrane oxygenation (the use of an artificial lung located outside the body that puts oxygen into the blood and pumps the blood round the body).
- The readmission rates for children over the age of 1, following an elective admission and readmitted within 2 days of discharge, was as expected for paediatric surgery. The rates were higher than the England average for medical oncology and clinical haematology.
- The readmission rates for children under the age of 1 were higher than the England average for cardiology; cardiac surgery; paediatric surgery; neurosurgery; neurology and paediatrics.

Competent staff

- For all new staff there was a trust-wide induction that was then followed by a local induction programme. The trust-wide induction covered the mandatory subjects including, but not limited to, security, information governance, health and safety, infection control and customer care. In the NNICU/SCBU, staff were supported through a 4-week structured induction programme, in addition to the trust's 4-day induction. This included orientation to the unit, allocated time to complete mandatory training, shifts alongside experienced staff in each nursery, and specific training relevant to their role.
- For the year April 2013 to March 2014, 93% of nursing staff had completed an appraisal. As of November 2014, 89.33% had a current appraisal.
- Physiotherapy and occupational therapy staff were supported through 4–6 weekly supervision sessions and annual appraisals. For Division C, of which the children's services were a part, 90.45% against a target of 96% of allied healthcare professionals had a current appraisal.
- All members of the paediatric oncology outreach nursing service had completed palliative care training to enable them to support other staff and families when a child or young person was dying.
- Staff were supported to undertake additional training relevant to their role and the patient groups they were caring for. In the NNICU/SCBU, for example, there was a development pathway for staff nurses to follow. This included competency assessments to obtain skills

relevant to their role, and undertaking further education to gain a recognised qualification and additional skills required for career progression. On Ward E1, new staff were supported to attend a 5-day course called 'The deteriorating patient', followed by the neonatal high care course and progressing to a 5-day paediatric cardiology course.

- Healthcare assistants could be supported to progress to assistant practitioner level through the completion of additional agreed training and competence assessments. In the day care unit, one healthcare assistant had completed their foundation degree and was taking on additional roles.

- Nurse educators were based on the wards and had a role in ensuring that the staff had the skills required to care for the patient group in that area.

- In order to facilitate the smooth running of the day care unit as a nurse-led unit, 50% of nurses had completed additional training to become history takers, 30% were competent in cannulation and 40% were competent in taking bloods. The senior sister was being supported to complete the advance nurse practitioner training.

- Nurses in the recovery area of the children's operating department were trained in the care of sick children and intermediate life support training in line with current guidance.

- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within paediatric specialties rated their overall satisfaction with training as similar to other trusts. The overall satisfaction and experience in intensive care and paediatric surgery was an outlier above the national average. Handover in paediatric surgery, adequate experience and local teaching in paediatric respiratory medicine, and study leave in paediatrics were outliers below national average.

- In the GMC National Training Scheme Survey 2014 the PICU showed potential good practice in training for the areas overall: satisfaction, handover, induction, adequate experience and access to educational resources. Health Education Wessex graded the PICU as excellent for postgraduate medical training posts. A junior trainee doctor reported that they were well supported by senior staff and that the teaching was good. They said, " it was a good experience."

Multidisciplinary working

- For a young person who was approaching the time when they would need to move from children services to adult services, the hospital had developed an approach called 'Ready, Steady, Go'. The programme was for a child over 11 years old with long-term medical conditions, and it was to help them to get ready and feel confident about moving to adult services. The programme followed a stepped approach and was designed to help parents, carers and the young person to feel confident about their knowledge and skills, and their ability to manage their condition. This had been adopted by a number of the specialties and was being used for children with cystic fibrosis, asthma and diabetes, as well as endocrine, gastrological and kidney conditions. The initiative was implemented through the outpatient clinics and, in addition, four times a year, joint clinics with adult and children services were scheduled to take place.

- There was a multidisciplinary clinic for children with neuromuscular conditions. This was attended by a physiotherapist, an occupational therapist, a speech and language therapist and a consultant nurse.

- Multidisciplinary ward rounds took place daily on the orthopaedic wards and twice weekly on the neurology ward.

- The therapists (physiotherapists, occupational therapists and speech and language therapists) worked with nursing staff to ensure that they received the training they required (for example, how to treat babies in the NNICU requiring chest clearance).

- There was a liaison health visitor who met weekly with the family support coordinator and was informed of discharge plans for babies going home from the NNICU/SCBU. A social worker also visited the unit weekly.

- In the oncology unit, a weekly multidisciplinary team meeting took place and was attended by specialist staff, consultants, representatives from the palliative care team, a dietician and a physiotherapist. Telephone-conferencing facilities were used to facilitate the attendance of all representatives.

- There was a consultant paediatric psychiatrist and a paediatric mental health nurse who were available to support staff in all areas of the children's service.

- The children and young people were supported by play leaders and teachers.

Services for children and young people

- The specialist nurses took a lead role in discharge planning. This included an assessment of needs and early engagement with community teams to ensure that any additional equipment would be made available in a timely manner.

Seven-day services

- Medical staff rotas provided 24-hour cover at all levels including consultants.
- Overnight there would be two paediatric registrars, plus two registrars on the PICU and two on the NNICU; there was also an orthopaedic registrar on duty. Consultant paediatricians provided a 24-hour on-call service and were on site until 10pm. Consultant on-site cover was provided until 10pm on the PICU; for surgery and cardiology, consultant cover was until 8pm; for orthopaedic, urology, neurology and oncology until 7pm; and for gastroenterology until 5pm.
- The anaesthetic staff were not part of the child health group. However, 12 consultant anaesthetists provided on-call cover for the children's service. The children's outreach team provided a service from 8am to 1am 7 days a week. It was staffed by four band 7 nurses and led by one band 8a. They would attend the handover on the PICU in the morning and would follow through children and young people once transferred to the ward.
- There was no out-of-hours provision for dietetics or occupational therapy. However, other services were working to offer extend cover out of hours and 7 days a week, although there was no full 7- day service in all areas.
- At the weekend, there was a respiratory physiotherapist available each day 8am to 4pm and an orthopaedic physiotherapist 8:30am to 12:30pm. Out of hours there was an on-call service.
- There was a weekday pharmacy service from 9am to 5pm, with an extended dispensary service to 7pm. At weekends, there was a dispensary service from 9am to 1pm, with a limited clinical pharmacy service to the medical unit (9am–3pm). The technical services unit provided a limited service on Saturday mornings 9am–1pm. On bank holidays, the pharmacy provided a dispensary service from 9am–1pm. Out of hours, there was an on-call pharmacist available.
- There was an on-call radiology service.

Access to information

- Policies and protocols were kept on the hospital's staff intranet so that all staff had access. At local level, there was a child health policy group that met monthly and had a role in reviewing policies and ensuring they were current. Any new polices had to be approved at trust level. There was also a trust-wide group that this group fed into. If something new was published, staff were informed through the children's hospital newsletter.
- Ward clerks had a role in ensuring that notes were accessible and available for planned admissions.
- In an emergency, patient records would be made available between 4 and 18 hours, because some records were stored off site.
- Investigation results were available through an electronic reporting system, and urgent results for blood test could be available within 30 minutes.
- There was provision in the NNICU/SCBU to ensure that parents had completed a Personal Child Health Record (PCHR). We saw in outpatients that parents were encouraged to bring these record books with them.

Consent

- The consent forms we reviewed had been completed in their entirety and described the benefits and risk of the intervention. When appropriate, they had been signed by both the parent and the child or young person.
- Two young people confirmed that they had been involved in the discussions and decisions about their treatment and had been invited to sign the consent form.
- We observed the taking of consent and saw this done in a caring sympathetic way with clear and accurate information shared.
- End of life discussions were consultant led. They were observed to be open and transparent with families involved in the decision making.
- The 'Gillick competency' and 'Fraser guidelines', used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions, were being applied continuously with both children/young people and their families being involved in the decision-making process and the consent to treatment.

> **Are services for children and young people caring?**

Services for children and young people

Outstanding ☆

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as outstanding.

Children and their families were treated with compassion, kindness, dignity and respect. This generated an atmosphere and ethos around caring for children and their parents. Staff involved children and their families in decisions about their care and treatment. Play leaders and youth support workers were involved in working with children to ensure they understood what was happening and why, in their care and treatment.

Children, young people and their families were positive about the care and support they received from all the healthcare professionals. Parents were positive about being able to stay close by and involved in their child's care. In areas where children were frequent attenders due to the nature of their illness, peer support through social events was encouraged.

Peer-to-peer support was promoted and encouraged in the oncology service. The youth support worker was an advocate for young people and was well thought of and respected by both them and their parents.

Before discharge, parents were supported in the neonatal intensive care unit (NICU) or special care baby unit (SCBU) to stay and care for their baby independently, with support close by. Mothers whose baby had been in the NNICU/SCBU were invited to coffee mornings when nursing and physiotherapist support was available. Following a bereavement, support for the family was available from a psychologist and the chaplaincy team.

Compassionate care

- We observed that children and their families were treated with compassion, kindness, dignity and respect. This generated an atmosphere and ethos around caring for children and their parents.
- In all areas, staff had received compliments in the form of thank-you cards. These included thanks and gratitude for their time and commitment to providing a compassionate caring experience. For example, two

quotes from thank-you cards for the neurosurgical ward were "You are amazing!!! You are kind, caring, highly professional people, we will always be grateful for everything you've done to make (my child) better", and "We will never be able to find the words to thank you for all that you have done for (my child) and us, you will be in our hearts."

- One young person told us, "There was a nice friendly atmosphere and the nurses are all really nice."
- We observed respectful and caring interactions between physiotherapists and children and their families.
- A mother in the NNICU said that "Both the nursing and medical staff were very caring."
- Young people on the teenager and young adult oncology unit had fed back, "The ambience of the unit is inviting and not scary; nothing cries out medical" and "It is nice to be able to socialise with people your age and feel less like being in a hospital environment."
- A young person in outpatients told us, "They are helpful, caring and supportive. Sometimes the clowns come and they make the children feel happy. There are hard things children go through but talking to staff makes them feel better. There are lots of things to take their minds off their problems."
- The children's medical unit had a 40% response rate to the NHS Friends and Family Test and 100% of the respondents said they would recommend the ward. Ward G3 had a 33.3% response rate and 89% said they would recommend the ward.

Understanding and involvement of patients and those close to them

- Children, young people and their families told us that they were kept informed and involved in the decision-making process.
- We observed staff with a caring approach; they ensured that they spoke to both the child and their family about events in ways that they could understand and in a way that was reassuring. The play leader spent time with a child who was a new admission, working with them to ensure that they understood what was happening while helping them to familiarise themselves with the environment.
- There was a youth support worker on the young adult oncology unit who had a role as the young people's advocate. They worked with the clinical staff to ensure

that they explained diagnosis and treatment in plain language and in a way the young person could understand. In other areas, the play leaders would act as support and the young person's advocate.

- A parent told us, "They felt reassured by the physiotherapist explanation of the problem and the treatment plan." Their child said, "They felt happy with advice and explanations."
- A mum whose baby had been in the NNICU/SCBU for 2months was positive about the amount of information they had been given since the birth of her baby.
- Parents were able to stay and care for their baby in a private room where support was available from the nursing staff to help prepare them for the discharge home.

Emotional support

- The hospital had a chaplaincy to support patients, family and friends regardless of their faith. There were a number of chapels and quiet rooms across the hospital where people could sit quietly or pray privately. These rooms were open 24 hours a day. There were Anglican and Roman Catholic chaplains, and visits by representatives of other faiths could be arranged as requested. A duty chaplain was available 24 hours a day for any urgent needs.
- Young people in the teenager and young adult oncology unit were supported by a youth support worker. They described their role as promoting as normal a life as possible for the young people and helping them to become emotionally stronger. Letters from young people and their families were complimentary about the role of the support worker, the amount of support they offered and the tolerance they showed in gaining a rapport with the young people.
- The NICU/SCBU held coffee mornings for mums. Mums said that this was a talking shop where they supported each other, and they found it reassuring and helpful. A nurse and a physiotherapist would attend to offer advice and support if needed.
- There was a dedicated family room in the NNICU and the PICU so that conversation could take place in private.
- When a child or young person died, a psychologist was available to provide support to staff and patients. This was in addition to the support provided by the chaplaincy team.

- Peer support was encouraged for children with cancer, long-term or chronic illness. For example, children undergoing chemotherapy on Piam Brown were supported through social events with their peers and, on completion of their treatment, they were invited to attend a residential weekend with their peers.
- Parents and carers could accompany children to the anaesthetic room and stay with them until they were asleep; they could also be with their children in theatre recovery when they were awake.
- Families were able to stay close by and be involved in their child's care. One mum told us" I was so relieved to be able to stay by my daughter's bed side."

Are services for children and young people responsive?

Requires improvement ●

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as requires improvement.

The hospital had dedicated facilities for children and young people. However, these were not ideal and staff were working to ensure the responsiveness of services. Children's services were in an adapted adult area and, although adaptions had been made over time, the actual environmental footprint or space had become too small for the services being delivered. The services were also divided over several levels and not located in one block. This was recognised by the trust and was on the risk register. There were plans to start work that would enable the relocation and expansion of two wards. There were proposals for a new children's hospital on site but these plans had been delayed because of funding problems and new funding proposals were being considered. The new hospital was planned to open in 2020.

There were only a limited number of preadmission and assessment clinics taking place to prepare children in advance and to ensure that the required information was readily available and used for assessment. There could be waiting times for up to a week for the rapid access fracture clinic, and children often stayed in the PAU for more than the expected 24 hours, because inpatient beds were not available.

Services for children and young people

The environment and facilities on some of the paediatric wards, however, required refurbishment and improvements to ensure access for children who might have disabilities or poor mobility. There was no dedicated space for young people other than the oncology unit and, although attempts were made to group these children together, this was not always possible.

Staff were working to improve access to services (for example, the extended clinics in orthopaedic physiotherapy service and the back pain clinic). Senior staff were looking into ways to use facilities more effectively. These included longer opening times for the outpatient department and changing a bed for two treatment chairs in the day care unit. Medical staff were working in partnership with Health Education Wessex in order to ensure that staff in the district general hospitals had the skills required to care for a sick child. They were also working to provide a surgical service closer to a child's home.

The children's areas were colourfully decorated and age-appropriate toys and games were available. Children and young people had good access to specialist care, such as a mental health nurse and a psychologist. Complaints were taken seriously and investigated and, when necessary, changes in practice occurred as a result.

Service planning and delivery to meet the needs of local people

- The hospital had dedicated facilities for children and young people. These were in an adapted adult area and, although adaptions had been made over time, the actual environmental footprint or space had become too small for the services being delivered. The children's wards were split over three different levels. The cardiac ward was on level E, along with the recently relocated children's operating theatres; the other wards were grouped together on level G, apart from the paediatric intensive care unit, which was on level D; and the outpatients department was on level C. This was recognised by the trust and was on the risk register. There were plans to start work that would enable the relocation and expansion of the PAU, which would move to be next to the dedicated children's emergency department, and the day care unit, which would expand and be divided into medical and surgical. Any additional work was dependent on the proposed children's hospital. The trust did not have sufficient funding to go ahead as planned with this new hospital, and the trust

board had made a decision to delay this work. New funding streams were being considered, including charitable funds. Depending on funding, the new hospital had an expected opening date of 2020.

- Outpatient clinics were held at a variety of locations to make them more accessible to the population the hospital served. In addition to Southampton General Hospital, these included, but were not limited to, Queen Alexander Hospital in Portsmouth; West Dorset Hospital; Royal Hampshire County Hospital; and Salisbury District Hospital. The trust was also working to provide a surgical service closer to a patient's home, with surgeons travelling to other hospitals to provide the service.

- There was a dedicated children's outpatient area and staff from this department ran the ophthalmic outpatient clinic that was based in the general eye department. There was a dedicated operating department with five theatres, one a theatre for cardiothoracic surgery for children and young people.

- Children up to the age of 16 were nursed on the dedicated children's wards; those between the ages of 16 and 18 were given a choice between the children's wards and adult wards.

- There was a team of speech and language therapists, consisting of 1.6 whole-time equivalent staff. The trust was investing in this growing service and clinics were being developed.

- The musculo-skeletal physiotherapist worked 2 long days a week to enable children and young people to attend clinics before and after school. The service was not fully operational and the waiting times were longer than desired because of the need to recruit more staff. This was being addressed by the trust.

- The home care team supported families in taking babies home from the neonatal intensive care unit (NNICU) or special care baby unit (SCBU). The team helped to bridge the gap between the units and the community. It helped families with feeding children through a tube at home and in looking after babies needing oxygen therapy. Its support enabled babies to be discharged home at an earlier age.

- If a sick baby in the NNICU/SCBU required surgery, then, in partnership with the paediatric surgeons and following an agreed protocol, surgery could be performed in the NNICU at Princess Anne Hospital. This way, the baby would avoid a stressful transfer from one

hospital site to another. One mother was positive about the experience when her baby had their patent ductus arteriosus (PDA, a congenital heart defect) ligated on the unit.

- The paediatric intensive care unit (PICU) worked collaboratively with Oxford University Hospital NHS Trust to provide a paediatric intensive care retrieval service to transport sick children. The unit had nursing staff who had received additional training to help run this service. There were 20 nurses who rotated through the role, ensuring that there was one nurse available at all times to be part of the retrieval team if required.

- The trust was working in partnership with Health Education Wessex to train district general hospital staff in managing acutely ill children. They were also working with anaesthetists at district general hospitals to improve their skills in intubating and anesthetising children.

- An accelerated rehabilitation pathway for children undergoing single-event multilevel surgery (normally children with cerebral palsy) had been introduced. The pathway had been developed to improve postoperative follow-up, with a reduction in recovery time from 18 to 9 months. The pathway required multidisciplinary working, including a surgeon, physiotherapist and occupational therapist, as well as equipment reviews and home adaptions by joint working with community therapy services. The pathway required the use of braces rather than plaster casts, and initial findings had been encouraging with positive feedback from both families and therapists.

- There was a plan to expand the NNICU/SCBU facilities, moving the SCBU nursery to a different floor to enable some reconfiguration and expansion of the NNICU. All the staff were informed about this proposal.

- Staff in the PICU were supporting the development of the nursing staff. They were developing a nurse-led extracorporeal membrane oxygenation service (using an artificial lung located outside the body to put oxygen into the blood and pump the blood round the body). This had been a perfusionist-led service. Unit staff were working collaboratively with Glasgow to train nurses who would then be able to relieve the perfusionist. An advanced nurse practitioner had recently been appointed who help in completing their training.

Access and flow

- The paediatric assessment, paediatric medical, children's neurosurgery, paediatrics, paediatric nephrology, paediatric cardiothoracic and the oncology and haematology units between them had 115 beds for the year 2013/14. Therefore, 41.975 bed days had been available. The actual occupancy level for the year was 72%.

- The PICU had 13 levels 2 and 3 beds. Between March 2014 and August 2014, the number of bed days used had varied between 355 in June (the lowest), and 391 in March (the highest) based on the critical care minimum dataset.

- A large number of specialties held children's outpatient clinics in August 2014. Approximately 5,500 children were seen in outpatient clinics and staff told us that the outpatient department was working to capacity and it was difficult to introduce new clinics. Alternative ways were being investigated to expand the department, such as offering more evening and weekend clinics.

- There was a limited number of pre-admission assessment clinics that would help prepare a child and their family, and ensure that their needs would be safely met. Children attending for ear, nose and throat (ENT) procedures were seen for a pre-admission assessment by the clinic nurse, because the clinic was held at another hospital. Some specialist nurses undertook some pre-admission assessments (for example, for spinal patients).

- There was a paediatrics rapid access fracture clinic in paediatric orthopaedics, where children were seen between 48 hours and 1 week.

- The paediatric assessment unit (PAU) was a 10-bed unit that could see up to 40 children and young people in a day. Patients could be referred to the unit by GPs and the accident and emergency (A&E) department, and known patients could have direct access. Staff reported that the unit often became 'bottle necked' because of the challenges of moving patients requiring admission to the wards. It was intended that children should only be on the ward for 24 hours but they could stay up to 3 days. We requested figures to demonstrate how frequently this happened, but these not provided.

- There was a paediatric physiotherapy-led back pain clinic. This had been introduced in response to an increase in referrals to the physiotherapy outpatient service for patients with back pain. The rise in referrals and waiting list resulted in a significant breach in the

Services for children and young people

18-week target from referral to the start of treatment. The physiotherapy clinic had resulted in a decrease in consultant waiting times and an improvement in the 18-week target for these children and young people.

- In response to an increase in demand on the paediatric orthopaedic therapy service, a Saturday service had been introduced in 2012 and had recently been increased to include a Sunday service. The expected standards were that all appropriate orthopaedic patients were seen by a member of the therapy team within 24 hours of surgery or admission; patients with the potential of a weekend discharge were assessed by a member of the team and discharged when appropriate. These standards were being adhered to and the trust was benefiting from the number of bed days saved.

- The day care unit had seven beds and two chairs. In recognition of the demands on the service, one bed was due to be removed and replaced with two chairs. Both medical and surgical patients were seen in the unit. This was a nurse-led service with embedded extended nursing roles including prescribing, cannulation and the discharging of patients. There were clear criteria for the discharge of surgical patients; most would be discharged within an hour of returning to the unit, unless the procedure undertaken (such as tonsillectomy) required an extended period of observation. Specialist nurses also had dedicated allocated time on the unit to provide services (for example, for allergy testing).

- The day care unit was working to capacity without any further room for expansion. We were told that more children and young people (and particularly those with a medical condition) could be seen on the unit if there was more space. There were plans to split the day care unit into two units (one for surgical patients and one for medical), but this was dependent on funding for the start of the building work for the redesign of children's services and the new children's hospital.

Meeting people's individual needs

- There was a dedicated teenage and young adult oncology unit and this had been designed and built to meet the needs of this age group. One young person described the facilities as "really good". There were six

inpatient beds and two beds and two chairs for day cases, a social space, a dining room where families could eat meals together, games, a jukebox, TV, DVDs and a kitchen area.

- There was no other dedicated ward for young people . On some wards, there was an attempt to group young people together; however, this was not always possible. On Ward E1, we saw a teenager in a 4-bed bay with a toddler, although on E1 there was also a dedicated rest room for teenagers and young adults to use that had a pool table, football table, computer and TV. There was a small kitchen area, too, for them to make their own refreshments. On Piam Brown, while there was a sitting room for young people in the day time, this also doubled as the classroom.

- The wards and department areas were decorated with age-appropriate décor, and toys and entertainment devices were available for children to use. The outpatients department was decorated with stimulating wall art, tactile Perspex sculptures such as space ships, and an interactive floor mat. One young person told us she had been able to watch a film on a portable TV and had been given a portable electronic device for playing games.

- Accommodation was available for families to stay close by. There was a dedicated parent accommodation called Ronald McDonald House, a house called Rotary House and a third house where families could stay for a small charge. Parents of children in the oncology unit could stay at CLIC house where the hospital had four rooms for families to stay in. There were also some rooms in the hospital dedicated for parents' use so that they could stay close to the wards or, in some places, sleep next to their child. This ensured that parents and families could be involved in their child's care.

- The environment for patients on Piam Brown was poor. There was a lack of space, the heating system was inadequate, there were ongoing leaks from the roof, and the wardrobes for pull-down beds were in a poor state. Some ongoing refurbishment was taking place. The school room and play room on had recently been refurbished. Improvements to the bathroom facilities to include the installation of an accessible bathroom for the neurosurgical ward had been postponed, but we were told that this work was on the estates schedule and would be undertaken.

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- There were no toilet facilities on the PAU, so children and families had to walk into the main medical ward area to access these. This would remain the case until the building work on the children's emergency department had been completed and the ward moved.

- There were limited accessible bathroom and toileting facilities on Level G These included the paediatric assessment unit; paediatric medical unit; G4, Piam Brown and John Atwell wards; Bursledon House; and children's outpatients. On the two G4 wards, staff were unable to hoist a patient into a bath.

- There was a limited number of bathrooms that could be used by children and young people with mobility issues. The baths were not accessible and it was not possible to use a hoist. There was one shower chair shared between wards G2 and G3 and only one accessible wet room on G3. There were plans to improve the bathroom facilities and we were told that these would be undertaken in the next 6 months.

- The access to Bursledon was via a short flight of stairs, which meant that the facility was inaccessible to those who were unable to manage the stairs. The staff told us there were no plans to address this because of the risk of installing a lift and the risk that some children could abscond.

- Information leaflets stated the information could be provided in alternative formats including different languages, large print, braille or on audio tape. However, this information was provided in English and standard size print.

- The leaflet, 'Children's services information for patients, families and carers' asked parents to inform hospital staff if their child needed an interpreter or signer. The play leader on Ward E1 had been supported by the trust to learn Makaton, a form of sign language.

- The play leaders also had access to picture books to use with children and young people who had additional educational needs, to help prepare them for their hospital experience.

- There was a hospital school and teachers and teaching assistants provided educational support to children and young people. There was a school room where children could attend, or teaching resources were taken to the wards. This ensured that education continued for those requiring an extended length of hospital stay.

- One parent whose child had complex needs told us that the current admission had been a different experience from their previous one; they believed that lessons had been learned and more consideration was being given to their child and not just their child's condition.

- If a child or young person was approaching the end of their life, the consultants would work with the palliative care consultant to ensure that the needs of the family and the child were met. Children could be taken to the local hospice or home. If they were being supported to breathe, they would be transported to the location of choice, where the breathing support would then be removed. This had been achieved at short notice at the weekend: using the trust's own retrieval ambulance enabled a family to have their last moments together at a location of their choice.

- For children and young people with a mental health illness, direct support was available from a mental health nurse and psychologist employed by the trust.

Learning from complaints and concerns

- The leaflet, 'Children's services information for patients, families and carers', encouraged people to raise their concerns with staff or to contact the patient support service.

- From April 2014 to September 2014, there had been 16 complaints that related to the children's service and 315 written compliments.

- In the 12 months from August 2013 to July 2014, there had been 47 complaints. Three were still under investigation, 23.4% had been upheld and 46.7% partly upheld. In all these cases, an apology and explanation was given to the person making the complaint. The hospital's policy for handling concerns and complaints (2014) stated that an acknowledgment would be sent within 3 days and a time frame would be agreed for the investigation of the complaint. Information provided by the hospital showed that extensions to the agreed deadlines were negotiated when required.

- Changes had occurred as a result of the investigations into complaints. These had included the introduction of an information leaflet about sleep studies, , and a pain management plan for when the pain management team was involved in managing a child's pain, so that everyone had access to the required information.

Services for children and young people

Are services for children and young people well-led?

Good ●

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

The values of the service underpinned the working of the children's service. There was a clear vision and strategy for the future of the children's hospital that focused around the building of the new hospital. It has been acknowledged that this was a long-term vision. While some work was due to take place in 2015 that would start to make a difference to the capacity of the service, alternative ways of addressing the demands on the service were being looked into.

There was a clear leadership structure for all aspects of the service. Staff were supported and encouraged to be engaged in service developments and innovations such as 'Ready, Steady, Go' for children transitioning to adult services. Risks and the quality of the service were being monitored and changes were taking place as appropriate. There was good engagement with staff to improve the service. There was effective engagement with children and young people and their families. Feedback was used to improve and develop services for example, in the development of the teenager and young adult oncology ward, and through the use of 'You Said, We Did' information displayed in ward areas.

Vision and strategy for this service

- Staff in the child health service described their values as being committed to providing care for children and supporting their families to the highest possible standard. This was at the heart of their continuing vision and strategy to be an excellent provider of children's acute care. They recognised that young people heal best when their families are part of the team, and they were committed to providing patient- and family-centred care. The key principles were dignity and respect; information sharing; participation and working together.

- The vision and the strategy for the service was to have a dedicated state of the art children's hospital bringing all the paediatric services under one roof for the first time. This was the main focus for the child health department. The trust did not have sufficient funding to progress with the new hospital and the plans had been delayed. This meant that work to complete the first stage of the hospital, the children's dedicated emergency department, had also been delayed. The emergency department was described as the key to unlocking the project because this would enable the relocation of the paediatric assessment unit (PAU), and free space for the development of the day care unit. The work on the emergency department was now due to start in 2015/16 but would take 9–12 months to be completed.

- The emergency department work would enable the expansion of some services but it would not fully address the capacity issues identified in the ward and clinic environments. This would not happen until further space became available in the form of the new children's hospital. For example, the new hospital would include a dedicated area for young people and bring the children's services physically closer together. Those services that were restricted because of the number of available beds, such as the children's inpatient oncology service, would be able to expand.

- We did not see evidence of an overarching clinical strategy to manage current issues, though individual services had completed service reviews. There were some ongoing plans to deal with issues as they materialised. Senior staff were looking at alternative ways to expand the service using available resources. This included increasing surgery by adding three theatre sessions, and extending the opening times and clinic times in the outpatient's department.

- There was some uncertainty about the future of the children's cardiac service because the judicial review was ongoing and the consultation process had only just closed. The cardiac services team and the trust were pursuing the prospect of being one of the centres to provide this service. This situation was not distracting staff from their goal of providing excellent care.

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Governance, risk management and quality measurement

- There was a risk register in Division C, of which children's services were a part, and the issues with the environmental space were recorded and monitored there, as were the capacity issues. There was evidence that the register was monitored and reviewed, and action taken whenever possible to remove the risk. For example, delays in staff completing their training in practical manual handling had been addressed by more staff being trained as trainers and extra training session being provided.
- The effectiveness of the Saturday and Sunday paediatric orthopaedic therapy service had been evaluated. The results showed the effectiveness of the service and the positive impact on outcomes with more patients being seen and an increase in weekend discharges. There had also been a positive impact on financial savings for the trust.
- Governance was a standing item on the agenda for the division board meeting that took place monthly.
- A monthly meeting referred to as Quality Education Sharing Together (QuEST) took place. This was a multidisciplinary meeting that was open to all disciplines and specialties. The intention of the meeting was to discuss and share learning from incidents, adverse events, root cause analysis (RCA) and specific case reviews.
- Performance was monitored through the clinical quality dashboard and saving lives audits.

Leadership of service

- Staff reported that they felt listened to by managers and clinical leaders. One example given was the support given to the neonatal intensive care unit (NNICU) to enable the unit to increase its staffing levels in line with national guidance.
- Staff reported that the director of nursing and chief executive officer were visible and visited different areas of the trust.
- Consultants were clear that their job plans covered all aspects of their role including shift patterns and leadership responsibilities.

- There was an established leadership structure. There was a medical lead for the care group, an operating officer and a general manager. There were six matrons who led the nursing service. The care group leads reported to the divisional leads.
- Each ward had a senior sister or ward manager who reported to one of the six matrons, who in turn reported to the divisional lead nurse. There were over 60 specialist nurses with specific roles who also reported to the matrons.
- The operation manager was clearly visible, with their office in the same area as the wards.
- There was a dedicated bleep holder for each shift who acted as the bed manager. They had clear oversight of capacity and planned discharges and would take a lead role if a major incident occurred.
- Out of hours, a senior nurse would provide telephone support.
- Senior sisters and ward managers were, or were about to become, supernumerary. They reported that this had made their jobs easier, they were now able to manage and it no longer felt like they were 'firefighting'.

Culture within the service

- Staff told us that they felt valued and respected and worked well together as a team.
- We observed an open culture with staff seeking advice and support from each other.
- Staff were engaging with the favourable event reporting and were nominating their colleagues. This included nurses and medical staff. One medical team had been recognised for forward planning and prescribing, the day before discharge, medication for patients to take home.

Staff engagement

- Staff were kept informed through unit meetings, the children's hospital newsletter and the risk newsletter. All staff groups were also invited to morbidity and mortality meetings. These meetings gave clinicians the opportunity to discuss errors and adverse events in an open manner, review care standards, and make changes if required. Summaries of the discussions at the QuEST meetings were also circulated in the form of a bulletin.

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- Two-yearly staff survey results, undertaken as a stress assessment, had shown positive results in relation to team work, peer support and clinical credibility. Negative comments related to the delay in the recruitment of new staff.
- There was a guidance leaflet available for staff about raising concerns and 'blowing the whistle'. We reviewed the trust's summary of whistle-blowing cases from 7 October 2013 to 19 June 2014. None of these related to children's services.
- Nursing staff had attended staff focus groups in September and October 2014. They had been able to discuss what they were doing well, what could be changed or done differently, and where action had been taken to make changes. Things that staff felt the children's services did well related to better staffing levels; team work; teaching opportunities; motivated teams; and outreach support. Things that staff felt could be done better related to equipment and the need to celebrate success. Since then, 15 new saturation monitors and 5 new machines to deliver oxygen therapy had been purchased. Also, the favourable event reporting form, to recognise and celebrate successes had been introduced.

Public engagement

- To ensure that children's voices were heard, the day care unit had developed the 'Pants & Tops' initiative. The children were invited to write down on templates what had been 'tops' positive or 'pants' negative about their hospital stay. Comments included, "liked play with the play lady", "everyone is very nice" and "don't like plaster".
- Families, children and young people were encouraged to give feedback via a questionnaire; this included a section for children to draw pictures to express their views. The feedback was displayed on each ward as 'What you said and what we did'. On Ward E1, they were using sharks and fishes symbols for children to add comment. Comments were clearly displayed along with any action (for example, one request was to limit the number of visitors, and information was clearly displayed requesting that there only be two visitors per child).
- Feedback on the paediatric physiotherapy-led back pain clinic was positive. Fifty-five completed questions showed a 98 to 100% satisfaction rate and no complaints about the service.

- There were two young people who represented the young people in and around Southampton and, to ensure that they had a voice, they met with the board of governors. They also had a Facebook page to help with external communication with the local population.
- In September 2014, the trust held an open day with a 'through the key hole' theme, aimed at giving people the opportunity to learn what went on behind the scenes. Children were able to pretend to be a surgeon, play stem cell pinball and visit the teddy hear hospital.
- Young people had been consulted about and involved in the design for the new teenager and young adult oncology unit. The unit was found to be clearly designed with the needs of young people in mind. Rooms were equipped with TV, facilities to make refreshments and mirrors behind shutters so that young people could prepare themselves before they saw their reflection.
- Children and young people had been consulted about what they would like to see in the new children's hospital. This feedback was displayed using pictures and words in a colourful presentation in the lift lobby. Comments included an outside play area, internet access, a sensory room and separate areas for boys and girls, particularly teenagers. There was a dedicated teenager ward included in the plans for the new hospital and the trust was working towards providing internet access across the children's hospital.
- The play leaders invited some children to become secret agents. A child was given an agent's bag and encouraged to record their experience in a notebook that was then handed in at the end of their stay.

Innovation, improvement and sustainability

- The paediatric department won a Wessex Notable Practice Award 2013 for 'Changing the culture of morbidity and mortality reporting'.
- The day care unit had developed the 'Pants & Tops' initiative so that children could write down what had been 'tops' or 'pants' about their hospital stay.
- The hospital had developed an approach called 'Ready, Steady, Go' for children transitioning to adult services.
- Staff were invited and encouraged to nominate their colleagues for recognition of their work through the favourable event reporting form. They were encouraged to nominate colleagues for recognition for looking after

each other, good practice and excellent initiatives. For the month of December 2014, the sister on the medical unit had been recognised for excellent leadership and facilitating patient care.

- The paediatric intensive care unit (PICU) had participated in two randomised controlled trails: the 'CHiP-control of hyperglycaemia' investigating the benefits of tight glycaemic control, and the CATCH investigation of the outcome and benefits of using three types of central venous catheters to prevent catheter-related blood stream infection.

End of life care

Safe	**Requires improvement**	🟠
Effective	**Requires improvement**	🟠
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢
Overall	**Requires improvement**	🟠

Information about the service

In 2013/14, 1,947 people died in the trust. The trust included an in-patient hospice and community palliative care service. Much end of life care was delivered by the UHS Specialist Palliative Care Service which operated in all health care settings including the acute hospital. Patients with end of life needs are cared for on the general wards of the hospital. They are supported by a consultant-led hospital palliative care team. This team provides specialist advice, support, training and education in palliative care across the trust, as requested, and also to the local hospice. It consists of one consultant (0.85 whole-time equivalent) and six (4.6 wte) palliative care clinical nurse specialists. The community specialist palliative care service and the local hospice also come under the remit of the trust.

In addition, the end of life care team support staff on the wards to provide care for acute hospital in-patients who are at the end of their lives. This team consists of one end of life clinical nurse specialist and three end of life care facilitators who started in their roles in July 2014 and support staff on some wards. There were end of life care link nurses who act as champions for end of life care on the wards. They take on additional training for this role and are given time to attend meetings and training sessions. The end of life team works closely with staff across the trust to embed the new end of life care strategy. Both teams are well supported by the bereavement support staff, the chaplaincy team and the mortuary staff.

During the inspection we visited general medical wards, the oncology wards, general surgery and orthopaedic wards,

the bereavement office, the mortuary and the chapel. We spoke with 5 patients, 6 relatives, 25 nurses, 6 consultants, 10 healthcare assistants, 3 ward sisters, 3 matrons, 4 managers, 6 domestic staff and 5 volunteers. We also spoke with 3 mortuary staff and 4 members of the chaplaincy team.

End of life care

Summary of findings

There were procedures to ensure that end of life care was safe and met the needs of patients. Incidents were reported and lessons were being learned, medicines were appropriately managed and equipment for end of life care was available and well maintained. Patients were appropriately monitored and the trust took part in the National Care of the Dying Audit – Hospitals (NCDAH) 2013/14 which was an audit of documentation of patients who received end of life care.

The trust was in the process of introducing a new care plan to replace the Liverpool Care Pathway after its national withdrawal in July 2014. The new end of life care plan (called Achieving Priorities of Care) had been piloted on selected wards in August 2014. However, wards without care plans did not have proper documentation and some patients' care needs and risks had not been fully assessed. Some 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not completed in line with national guidance. The trust needed to increase palliative medicine input to the acute hospital and ensure that mandatory training on end of life care was available.

The hospital was developing end of life care in line with national guidance. The results of the 2013/14 NCDAH had highlighted a number of areas for improvement. The hospital had since made some progress on the implementation of the action plan but there needed to be more staff education and training around this.

Some DNACPR forms we inspected were not completed according to national guidelines. Hospital audits had also identified areas for further improvement, to ensure that forms were signed and verified by a consultant, for discussions with patients and families, and to document mental capacity decisions.

Staff supported patients and their relatives and provided compassionate care. They ensured that patients' privacy and dignity were maintained. Patients received good information regarding their treatment and care. The service took account of their individual needs and wishes, and their cultural and spiritual needs.

The bereavement support staff provided good support to relatives after the death of a patient. The hospital had a rapid discharge service for discharge to a preferred place of care.

There was pressure on the service in terms of capacity. Improvements to the service were being made, for example in January 2015; the trust opened four palliative care beds within the oncology/ haematology wards. The trust's revised draft strategy for end of life care was recently developed based on national guidance. There was a steering group to monitor performance against national standards and a trust board leadership for end of life care recently developed. Members of the team that provided end of life care within the trust were passionate and committed to improve the service; staff in the trust wanted to provide good end of life care. The trust had made improvements in engaging with the public and had plans to innovate and improve the service.

End of life care

Are end of life care services safe?

Requires Improvement ●

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

The trust was in the process of introducing a new care plan (called Achieving Priorities of Care) to replace the Liverpool Care Pathway after its national withdrawal in July 2014. This had been piloted on selected wards in August 2014. However, wards without care plans did not have proper documentation and some patients' care needs and risks had not been fully assessed

Some 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms were not completed in line with national guidance (for example, they were not signed by a consultant or the DNACPR reason was not appropriately identified).

The trust needed to increase palliative medicine in-put to the acute hospital and ensure that mandatory training on end of life care was available.

There had been a recent relaunch of the AMBER care bundle. This was an approach used in hospital when doctors were uncertain whether a patient would recover. End of life care coordinators were raising awareness across the hospital but its use was still being implemented. The team acknowledged, however, that they did not have enough time or support to roll this out effectively.

Incidents were reported and lessons were being learned, medicines were appropriately managed, and equipment for end of life care was available and well maintained. Patients were appropriately monitored and the trust performed well in the National Care of the Dying Audit – Hospitals (NCDAH) 2013/14 which was an audit of documentation of patients who received end of life care. Staff were aware of the major incident plan and actions to take in the event of a major incident.

Incident reporting, learning and improvement

- The end of life care nurse and the palliative care nurses were aware of their responsibilities to report incidents, and they did so using the hospital's electronic system.

Staff on wards told us that incidents they reported were investigated in a timely manner and they received feedback. Incidents were also discussed at weekly multidisciplinary team meetings.
- The staff were able to give us examples of where practice had changed as a result of an incident. For example, patients who received palliative care or end of life care did not have ward moves because of bed management pressures

Duty of Candour

- Duty of Candour is concerned with openness and transparency, and places a responsibility on NHS hospitals to inform patients when things have gone wrong and either severe or moderate harm has been caused.
- It was discussed at a weekly hospital specialist palliative care team multidisciplinary team meeting and an end of life care team meeting.
- Staff we spoke with had an understanding of the Duty of Candour. While they had not received any formal training on it, guidance and information were available to them.

Cleanliness, infection control and hygiene

- The mortuary was visibly clean. It was cleaned every day at the end of the day by a specially trained cleaner.
- The palliative care and end of life care teams were aware of their roles and responsibilities with regard to infection control. They wore clean uniform and were 'bare below the elbow' in clinical areas. The staff had access to personal protective equipment and we saw that they used it appropriately.
- Two patients and three relatives told us they observed staff wearing protective clothing and washing their hands between seeing patients.

Medicines

- We observed staff follow the medicines policy and manage controlled drugs in accordance with the Controlled Drugs Regulation 2013.
- Patients were prescribed appropriate medication for symptom and pain management.
- Anticipatory end of life care medicines were appropriately prescribed. This is medication that patients may need to make them feel comfortable. When patients left the hospital, they were discharged

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with these medicines. On the day of our inspection, we spoke to a relative who told us about these medicines and how arrangements were made to give them to patients.

- There were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients.

Environment and equipment

- Equipment was regularly maintained and checked to ensure that it was safe to use.
- Staff told us they did not have any problems getting mattresses and syringe drivers for end of life care patients.
- Equipment used in the mortuary was maintained and checked regularly. The trolleys and refrigeration system were checked weekly by the mortuary staff and bi-annually by the external contractors. We were shown records of such checks.
- Patients were equipped with call bells in order to attract the attention of a member of staff when necessary.
- There were contingency plans in place for bariatric patients. Mortuary staff had received appropriate training in the storing of deceased bariatric patients. Porters had received specialist training in the removal of a bariatric patient from the ward.

Records

- In all the ward areas we inspected, we saw that records were stored securely and could only be accessed by people who had the appropriate authority.
- The trust had introduced a new end of life care plan (Achieving Priorities of Care) in August 2014; it was used on a few selected wards as a pilot from July 2014 to January 2015. This was in response to the national withdrawal of the Liverpool Care Pathway in July 2014. The feedback from this pilot had resulted in a revised end of life care plan that would be rolled out across the trust.
- Initial feedback from ward staff was varied. Some staff said the revised end of life care plan was a much better tool for recording information and for providing continuing care to patients. This was also confirmed by link nurses we spoke with. They told us the new documentation was more "user friendly". However, some staff said the care plan was difficult to use.
- For wards where the new care plans had not been introduced, the documentation of end of life care was not as robust. There were not appropriate risk

assessments or documentation of patients' care needs. This lack of documentation had been recognised by the trust and there were concerns that the care provided to patients could be adversely affected. The trust planned to audit documentation once the revised end of life care plan had been rolled out across the organisation by August 2015. End of life care facilitators identified that a lack of time and support was hindering the roll out and pilot.

- The mortuary had a robust system to record information about a deceased patient so that appropriate arrangements could be made with undertakers. .
- All resuscitation decisions were recorded on a standard DNACPR form. This form was kept at the front of a patient's notes, allowing easy access in an emergency.
- The trust carried out regular audits of DNACPR forms. The last audit for the period July to September 2014 looked at 40 forms. The forms included information such as the individual's clinical history and the reason for the decision not to undertake CPR in the event of an emergency. Thirty three per cent of the forms were not signed by a consultant and 28% were neither dated nor timed, nor both. Only 53% of orders were documented as having been discussed with the patient. It is possible that in some cases discussions could not be held with the patient because of their reduced level of consciousness, or the inappropriateness of holding a conversation with them at that specific time. However, 50% of orders noted discussion with a relevant person.
- Since the previous DNACPR audit in June 2014, there had been some improvements. For example, there was an increase (from 50 to 54%) in the number of decisions being discussed with patients. There was a significant reduction (from 18 to 5%) in the number of forms where there was no discussion held with the patient or significant other. There was an increase (from 63% to 67%) in the number of forms being verified by a consultant within the specified 48-hour period. An action plan had been developed and, in future audits, the trust would explore whether decisions not compliant with policy involved particular areas or individuals.
- We inspected 18 DNACPR forms throughout the ward areas. Some forms were appropriately completed. However, we found eight forms that had not been completed in line with national guidance published by the General Medical Council (GMC). For example, forms were not appropriately signed by a consultant or the

reason for the DNACPR was not completed adequately. One form gave old age as the reason why the patient was not for resuscitation. We identified these forms to the senior staff on the ward so that corrective actions could be taken.

Safeguarding

- There was a policy in place that outlined the processes for safeguarding children and vulnerable adults.
- Safeguarding training was mandatory. Staff from the palliative care and end of life care teams had undertaken safeguarding training. They were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.
- Staff were aware of the whistle-blowing policy and felt they could report any concern. They were confident that these would be addressed.

Mandatory training

- The hospital palliative care team and the end of life care facilitators said they had completed their mandatory training. This included training in fire safety, basic life support, moving and handling, and safeguarding adults and children.
- Mandatory training in end of life care was not provided to staff beyond the hospital palliative care team and the end of life care facilitators. The trust did not follow the national recommendations of the NCDAH 2013/14 for hospitals that mandatory training be provided for doctors and nurses.

Assessing and responding to patient risk

- There was an early warning system to identify when patients were deteriorating. Nurses were aware of how to use the tool and when to make referrals to a senior doctor.
- Patients at the end of their life were monitored appropriately.
- Staff were aware of how to escalate changes in a patient's condition to relevant clinical staff. In such instances, their first step would be to contact the specialist palliative care team for advice and guidance.
- There had been a relaunch of the AMBER care bundle. This was an approach used in hospital when doctors were uncertain whether or not a patient would recover. Generally, it was initiated when patients had a few months to live. Some staff were aware of the AMBER

care bundle and the end of life care facilitators were raising awareness of it on the wards. The team acknowledged, however, that they did not have enough time or support to roll this out effectively.

Nursing staffing

- The hospital palliative care team included 4.6 whole-time equivalent palliative care clinical nurse specialists.
- The trust also had three end of life care facilitators who reported to an end of life care clinical nurse specialist.
- The end of life care facilitators had recently been appointed (October 2014) and were charitably funded by Marie Curie Cancer Care until the end of March 2016. Staff told us they had already made a substantial impact on the ward in terms of advice on caring for end of life patients and helping wards with discharge arrangements. Their role was to actively promote the use of the AMBER care bundle and the piloting of the new care plan. They also provided 3-monthly training for the palliative care link nurses.
- There was also a modern matron with responsibility for specialist palliative care and end of life care across the trust including the hospital palliative care team and the end of life care team

Medical staffing

- There was a 0.85 whole-time equivalent consultant in hospital palliative care medicine. The trust had 1,400 beds and therefore medical staffing was not in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations or the National Council for Palliative Care guidelines, which state that there should be a minimum of 1 consultant per 250 beds. In January 2015, the palliative medicine consultant establishment in the trust increased to 1.2 whole-time equivalent.
- The trust had recognised that to increase medical engagement at all levels across the trust there was a need to develop a consultant-level end of life care lead role alongside the end of life care team. Plans had been agreed with the chief executive that the role would be supported with a specialist registrar and some additional consultant time. At the time of our inspection, these plans were gradually being implemented.

Major incident awareness and training

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- Both hospital palliative care staff and end of life care staff were aware of the major incident plan and actions to take in the event of a major incident.
- There was a contingency plan in place in the event that the mortuary became full, and there were arrangements with local undertakers. Staff could not recall when the mortuary was last full.
- The staff in the mortuary had received major incident training and were aware of any actions to take.

Are end of life care services effective?

Requires Improvement ●

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as requires improvement.

The trust scored below the England average on most of the clinical and organisational indicators in the National Care of the Dying Audit – Hospitals (NCDAH) 2013/14. Documents detailing end of life care principles had been introduced in August 2014, and the trust was piloting end of life care plans (called Achieving Priorities of Care) after the national withdrawal of the Liverpool Care Pathway in July 2014. Staff knowledge of these changes was limited, and nursing and medical staff were not clear when to make end of life care decisions. During the period of our inspection, the trust had reissued guidance.

Staff had awareness of the Mental Capacity Act 2005 but not all 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms were supported by mental capacity assessments when it was stated that patients lacked capacity.

Patients had appropriate access to pain relief. Anticipatory end of life care medicines were correctly prescribed and patients were provided with pain management support although this was not always well documented. They were also appropriately supported in terms of nutrition and hydration, and their religious and cultural needs regarding food were met.

The specialist palliative care and end of life care team members were competent and knowledgeable. Ward staff

required better understanding and training to support end of life care on the wards, and training was still to be implemented. There were good examples of multidisciplinary team working to centre care around patients and ensure continuity of care with GPs and in the community .

Patients had access to 7-day services although this was not a 24 hours service in the hospital. A clinical nurse specialist worked in the trust on weekends. Out-of-hours weekend support provided by the local hospice.

Evidence based care and treatment

- The end of life care team told us that, following the national withdrawal of the Liverpool Care Pathway in July 2014, guidance on the principles of care for dying patients had been introduced. The trust was also piloting a new end of life care plan on some wards. Based on the results of this pilot, the care plan would be rolled out across the organisation.
- However, during our initial inspection in December 2014, we found that staff had limited awareness of those principles, even on wards where the care plans had been piloted. In the absence of any guidance, both ward staff and medical staff told us they were not clear when to make end of life decisions. The trust reissued guidance to the wards after our initial visit. When we inspected the trust in January 2015, staff awareness had not improved about the principles of end of life care.
- The trust had a draft end of life strategy. This was based on national guidance such as the National Institute for Health and Care Excellence (NICE) quality standard 13, which defines clinical best practice in end of life care for adults, and the Department of Health's National End of Life Care Strategy. The trust had relaunched the introduction of the AMBER care bundle and there was input and support from the end of life care team to help implement this on the wards. The trust was piloting the 'Achieving priorities of Care' document, a care plan for end of life care. These were still being implemented.
- The NCDAH 2013/14 showed that the trust achieved a score of 60% for the number of assessments undertaken in a patient's last 24 hours of life; this was worse than the England average of 82%. Since that audit, wards had been given information on how to care for patients in the last hours of life. Staff told us this was updated regularly.

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- The service was made aware of end of life care patients through an internal flagging system. Some wards had a tool to identify dying patients. However, the trust's results from the NCDAH showed that the trust achieved a review of interventions during the dying phase in 36% of patients; this was worse than the England average of 56%. Staff told us that the new care plan documentation that the trust was piloting would improve this result.

Pain relief

- The trust's results from the NCDAH 2013/14 showed that, at the time of the patient's death, there was documented evidence that 'use when required' medication had been prescribed for 22% of patients; this was worse than the England average of 51%.
- Ward staff told us they had appropriate medication to use. They said that anticipatory prescribing was managed well. This was also confirmed by two pharmacists who visited the wards.
- The patient records we inspected showed that patients received appropriate pain relief. The records gave instructions to staff on action to take to meet patients' individual needs.
- Patients told us their pain and comfort were well managed. Relatives also shared positive comments regarding pain relief for patients.
- The palliative care team told us that pain management was a major part of their work on the wards. Their advice was sought and accepted.

Nutrition and hydration

- The NCDAH 2013/14 found that 35% of patients had a review of their nutritional requirements, which was worse than the England average of 41%. The same audit found that 41% of patients had a review of their hydration requirements, which was worse than the England average of 50%.
- The hospital used a screening tool, the Malnutrition Universal Screening Tool (MUST) to identify those patients who were nutritionally at risk. When patients were identified as at risk, fluid and food charts were put in place.
- Staff were aware of the GMC guidance on nutrition and hydration. Link nurses confirmed that care plans identified what patients could eat, and the plans were regularly updated.

- Staff explained to us how they addressed people's religious and cultural needs regarding food. This included the provision of halal and vegetarian food among various other options. Patients and relatives told us about the availability of a variety snacks and meals.

Patient outcomes

- On nine of the ten key indicators for clinical performance in the NCDAH 2013/14, the trust scored below the England average. . On the key indicators for organisational performance, it scored better or the same for six out of seven.
- The results of the NCDAH showed that 70% of the trust's patients were identified for end of life care when they were dying. This was better than the England average of 61%. The trust scored lower than the national average for those patients who had been assessed within their last 24 hours, with 60%, compared with the England average of 82%, being assessed.
- After the NCDAH audit, the trust developed an action plan to address these areas. This included reviews of patients' nutritional and hydration requirements, and care planning for the care of the dying in line with the NICE guidance.
- A recent action plan update (January 2015) highlighted that the trust had made some progress on all the clinical and organisational key performance indicators where it had performed worse than the England average in the 2012/13 audit. The actions taken on improving documentation would play a considerable role in improving the results but the service recognised that it had some way to go before it reached this milestone.
- The hospital palliative care team 'Patient's and carers' experience survey 2013/14' highlighted areas of good care and noted a great deal of satisfaction with the palliative care team. The survey highlighted that patients and carers had they received answers they could understand.

Competent staff

- The end of life care facilitators had developed draft competencies for end of life care. These were going to be rolled out to all care staff across the trust.
- The facilitators worked with the chaplaincy team to develop a 'Spiritual care competency passport'. A draft was shown to the inspectors.

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- Staff in the hospital palliative care and end of life care teams were supported to develop their knowledge and competencies in various ways including continuing professional development days, team meetings and further qualifications.
- The bereavement staff were supported in gaining qualifications (for example, in counselling).
- The hospital palliative care team and the end of life care facilitators had received clinical supervision and an annual appraisal.
- The chaplaincy team had requested to reinstate their clinical supervision, which had previously been withdrawn because of cost pressures. The request had now been approved and from March 2015 the team would receive clinical supervision.
- Staff were aware of how to use syringe drivers effectively and safely. Training for this was provided to relevant staff on a continuous basis. Records for this training were kept with the ward sister. We looked at the records of three staff and found they had received the appropriate training.
- Ward staff required better understanding and training to support end of life care on the wards, and training was still to be implemented.
- Many wards had a link nurse for end of life who was supported in developing their skills and knowledge in palliative care and end of life. Link nurses we spoke with said their role was welcomed on the ward and valued by other staff. They also received a special training programme every three months and were and supported by ward sisters to apply this knowledge back on the wards.
- Staff also had access to end of life information and guidance on the intranet. Staff found this resource valuable and easy to access. One member of staff told us, "Palliative care at this hospital is extraordinary."
- In the GMC National Training Scheme Survey 2014, the trainee doctors within palliative medicine rated their overall satisfaction with training as similar to that in other trusts. Clinical supervision, regional teaching and study leave were outliers above the national average; handover was an outlier below the national average.

Multi-disciplinary working

- The hospital had strong links with the local Countess Mountbatten Hospice, which was also part of the trust.
- There were strong links with the community palliative care team. This was a multidisciplinary team including clinical nurse specialists, doctors, social workers, physiotherapists and occupational therapists who supported patients with complex palliative care needs within the community setting.
- The hospital palliative care team multidisciplinary meeting was held once a week. The team reviewed all cases of palliative care including the appropriateness of medicines and achievement of preferred place of care. Patients who were discharged or died were also discussed including ongoing support to their families, when appropriate.
- There was a community multi-disciplinary meetings which hospital staff attended.
- The hospital palliative care team visited wards and provided teaching sessions to doctors on ward rounds.
- The hospital palliative care team worked closely with acute oncology clinicians in treating cancer patients.

Seven-day service

- The full hospital palliative care team was available 8.30am to 4.30pm Monday to Friday.
- One clinical nurse specialist was present at the weekends and on bank holidays between 8.30am and 4.30pm. Staff told us the service was well received and that most weekends and bank holidays were busy.
- The hospital had excellent links with the local hospice and community palliative care team and could access any specialist advice from clinical staff and from a palliative medicine consultant 24 hours a day. Staff confirmed that they could access advice and support from the team at any time.
- Chaplaincy support was available 24 hours every day, in person during office hours, and initially by telephone out of hours.

Access to information

- Staff had access to end of life information and guidance on the intranet. Staff found this resource valuable and easy to access.
- The workings across the community were enhanced because the hospice, the community palliative care team and the hospital end of life care team all operated in a single unified structure. This enabled transfer of care from hospital to community in a seamless manner. For example, a DNACPR form moved with the patient and was reviewed appropriately between the two settings. This ensured continuity of care.

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- Patients were discussed on a weekly basis at multidisciplinary team meetings and this gave GPs access to information.
- Each GP surgery had a named palliative medicine consultant and palliative care community clinical nurse specialist. This enabled access to information in a timely manner.
- Three relatives told us that staff ensured that their relative was pain free and kept comfortable. They told us they were involved in the discussions about the pain relief that was going to be used.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they received training on consent and the Mental Capacity Act 2005. When patients did not have capacity to consent to care and treatment, staff were aware of what actions to take.
- We reviewed 18 DNACPR forms during the inspection. One form stated that the patient lacked capacity to understand the decision around the DNACPR but there was no evidence that a mental capacity assessment (MCA) had been undertaken.
- There were consent arrangements in place for managing tissue removal after death, where this might be necessary for example for transplantation or research.

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Are end of life care services caring?

Good 🟢

By caring we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Patients were cared for by compassionate and caring staff, and we observed them being treated with dignity and respect. The chaplaincy team had undertaken a listening exercise with staff about compassionate care and the recommendations were being implemented across the hospital.

Patients told us they were well informed about their treatment and care. There was a bereavement support

team that provided support to relatives after the death of a patient. There was a special viewing room in the mortuary where relatives could spend time with their loved ones. Staff across the trust provided emotional support to patients and bereaved families. Volunteers from different faiths were used to support patients with religious needs.

Compassionate care

- We spoke with three patients who were receiving palliative care and they were highly complimentary about the staff. For example, one patient told us, "Staff are very caring and go out of their way to help."

- During our inspection, we observed that staff were compassionate and caring and treated patients with dignity and respect. All the staff we spoke to were very clear about their role in ensuring that people received appropriate support.
- We saw porters taking a body from the ward to the mortuary in a respectful manner.
- Staff told us they undertook comfort rounds regularly. Relatives we spoke with confirmed that regular checks were undertaken by staff.

- Chaplains were involved in undertaking a specific listening exercise on what compassionate care meant for staff working at the trust. As a result, 17 focus groups consisting of 107 staff from a wide variety of professions and grades came together to explore what compassionate care meant to them, and how could it be implemented. The 10 key recommendations from this report were now being acted upon across the organisation.

Understanding and involvement of patients and those close to them

- Families felt they were well informed about the condition of their relatives. They found the information helpful and it reassured them that their loved ones would be supported throughout their dying days. One person told us how this helped them to cope with the dying of their loved ones.
- Patients and relatives told us that the doctors were good at communicating with them about the care the patients were receiving. They did not feel rushed and their questions were answered in a detailed manner.

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- Relatives told us they were encouraged to get involved in the care of their loved ones (for example, to provide mouth care. Mouth care kits were available on the wards and placed at patients' bedsides.

Emotional support

- Chaplains and nurses provided emotional support to patients and relatives who were experiencing difficulties in coming to terms with death and dying. Relatives told us that the emotional support for patients with terminal illness was exceptional.
- Chaplains told us they visited the wards to support patients and relatives. They also arranged for volunteers from other faiths to visit people of those faiths. For example, they had a list of people from different faiths whom they could call on to ensure that a patient's religious wishes were met.
- Bereavement support staff provided support to relatives after the death of a patient. This included bereavement care meetings where relatives were provided with information on post-mortems, tissue registration donation, death procedures, funeral arrangements etc. Relatives showed much appreciation for such services, as shown in the complimentary letters received by the bereavement support staff.
- At a bereavement support meeting, relatives were given the belongings of the deceased in a special carrier bag purchased for this purpose. These meetings were pre-arranged to last 1 hour and staff told us they helped relatives to raise any concerns and get them addressed by the trust. At this meeting, relatives were given the opportunity to meet with clinical staff to discuss any concerns they had about the care of their relative and the last moments of the deceased's life. Staff from the bereavement team told us this opportunity was valued by relatives.

Are end of life care services responsive?

Good ●

The hospital palliative care team collected and analysed detailed information about patients to help provide a service that would meet people's needs. In January 2015, the trust opened four palliative care beds within the oncology/ haematology wards that could be accessed for end of life care. There was pressure on the capacity of the

service that had been recognised by the trust. There were ongoing discussions with commissioners on how the service could be improved to meet the needs of the local people. There was concern that the current service could end, because the end of life care team was only funded until the end of March 2016.

Most patients were seen by the hospital palliative care team within 24 hours . The trust had a rapid discharge service for discharge to a preferred place of care. The service took account of individual needs and wishes, as well as cultural and spiritual needs. The National Care of the Dying Audit – Hospitals (NCDAH) 2013/14 had identified that the trust needed to ensure that there were discussions with patients and/or their relatives about end of life care. This was appropriately documented during our inspection.

The specialist palliative care team had received no complaints from relatives regarding end of life care. The trust had started to analyse all complaints from January to December 2014 to ascertain if any related to end of life care.

Service planning and delivery to meet the needs of local people

- The hospital palliative care team provided specialist advice, support, training and education in palliative care across the trust. In addition, the end of life care team supported staff on the wards to provide care for patients who were at the end of their lives. Individual wards had end of life link nurses who acted as champions for end of life care on the wards.
- Staff on the wards felt that both the hospital palliative care team and the end of life care facilitators were helpful and approachable. However, there were concerns that the facilitators were only in post until March 2016 when the funding for those posts came to an end.
- The hospital palliative care team collected and analysed detailed information about patients to provide a service that would meet people's needs. This included information such as the number of referrals, referrals seen within 24 hours, where were patients seen and reviews undertaken. There were ongoing discussions with commissioners as to how the service could be improved to meet the needs of the local people. As a result of these discussions, weekend working for clinical nurse specialists had been introduced.

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- In 2013/14 they received 1571 referrals, of which 297 (19%) were for patients with non-malignant diagnoses. In the first 9 months of 2014/15 the number of total referrals increased and the percentage of referrals of patients with non-malignant diagnoses increased to 24%. The team were particularly proud of the marked increase in referrals from the four adult intensive care units; 47 referrals between April 2014 and end of December 2014 compared to 9 in the full 2013/14 year. They had a very high profile on the oncology wards where they were seen as part of the core team caring for patients.

- To improve the end of life care to patients in oncology, the acute oncology strategy included a new 5-bed ward area for acute oncology. This opened in December 2014. Oncology patients nearing end of life could access the acute oncology team and be assessed, and if necessary, given a bed rather than coming through the emergency department or the medical admissions unit.

- End of life care patients were generally offered a side room unless these were being used to nurse an infection-control patient. In such instances, the end of life care patients were nursed in the bays.

- Relatives were supported with refreshments and special parking permits that allowed them to use car park facilities at no cost.

- Relatives told us that they were able to visit the ward at any time when their relatives were approaching the end of life.

Access and flow

- Members of the hospital palliative care and end of life care teams were visible on the wards. Nursing staff knew how to contact them, but they were not always clear where to refer patients for end of life care. Referrals were made by telephone contact. If a patient was inappropriately referred to the palliative care team, they were promptly referred on to the end of life care team. Ward staff told us there were no delays in patients being seen.

- The NCDAH 2013/14 identified that access to specialist care in the last hours of life was similar to the England average.

- In 2013/14, 75% of patients were seen by the hospital palliative care team within 24 hours of referral, with only

2% waiting for more than 48 hours for a review. The number of patients with diseases other than cancer continued to increase. In 2013/14, 20% of the patients referred to the team had conditions other than cancer.

- The trust had a rapid discharge service for discharge to a preferred place of care within hours or a few days. There were plans to audit this in April 2015. The national average for patients with cancer dying at home was 17%. A recent trust audit (2014) had shown that this percentage rose to 47% for patients known to the specialist palliative care team. The recent appointment of the end of life care facilitators would improve this.

- In 2013/2014, the hospital palliative care team had 1,600 referrals and for April 2014 to December 2014 it had already received 2,000 referrals. This pressure on the service had been recognised by the trust and there were plans to support the team with additional consultant cover.

- Because of the close links with the local hospice, patients were transferred there as and when deemed appropriate. During our visit in January 2015, we saw how three patients on the wards were transferred to the hospice. The transfer was done in a seamless and coordinated manner.

- Four designated palliative care beds on the oncology ward had only recently become available (December 2014). Staff told us that it was too early to judge whether this improved access and the flow of patients through the service.

Meeting people's individual needs

- Whenever possible, side rooms were prioritised for patients at the end of life, unless these were being used to nurse an infection-control patient. In such instances, end of life care patients were nursed in the bays.

- Relatives told us that they were able to visit the ward at any time when their loved ones were approaching the end of life. Relatives were supported with refreshments and special parking permits that allowed them to use car park facilities at no cost.

- The trust took part in the NCDAH 2013/14. Sixty-five per cent of records reviewed showed that discussions with patients and relatives had taken place. This was below the England average of 75%. There had been a re-audit to see if any improvements had been made.

- The trust carried out regular audits of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms. The last audit for the period July to September 2014 looked

End of life care

at 40 forms. Fifty per cent of these were documented as having been discussed with the patient. It is possible that in some cases such discussions could not be held with the patient because of their reduced level of consciousness, or it was inappropriate to hold such a conversation with the patient at that specific time. Since the previous audit, there had been some small improvements. For example, there had been an increase in the number of decisions being discussed with patients from 50% to 54%. There was a significant reduction in the number of forms where there was no discussion held with the patient or significant other from 18% to 5%. This was a positive improvement.

- We looked at 18 DNACPR forms and care plans. We found that doctors had had conversations with the patients or their relatives and this was documented on the forms and in the patients' records. Two other forms did not show that discussions had taken place with the patients or any relative before the forms had been signed by medical staff.

- Staff told us how they respected families' cultural and religious requests and encouraged them to share their wishes with staff. For example, some relatives wanted to take the deceased to the mortuary and arrangements were made accordingly. Recently, relatives had requested a special room for prayers, and arrangements were made accordingly with the chaplain to meet the needs of the family.

- The trust had a transplant coordinator who gave information about organ transplantation. We saw that information booklets were available for patients and families to read in order to make appropriate and timely decisions.

- The bereavement support team coordinated tissue transplant. Team members explained how families could get involved and be supported through the tissue transplant process. As a result, tissue transplant donation had increased by 300% (from 20 tissue donations in 2011/12 to 60 in 2013/14) since the start of the service.

- There were various printed information leaflets available to patients and their relatives, and others for staff on what support to give patients and relatives. Staff told us they valued the leaflets provided by the chaplaincy multi-faith team on how to support people from different faiths. All information for patients was only available in English. Patients could ask for information in another language but that request was

also published in English, making it highly unlikely that a patient who spoke another language could access the information in their own language. We did not see any information in an easy-to-read format.

- The trust had a translation service for patients and relatives who did not speak English. Staff told us there were generally no delays in accessing this service when needed.

- NCDAH 2013/14 found that 23% of patients had a spiritual needs assessment at the hospital. This was lower than the England average of 37% and various actions had been taken. The high profile of the chaplains and the service they provided was noticeable on the wards. The chaplaincy multi-faith team had also organised training for ward staff on how to meet the needs of the various faith communities. Leaflets on this were also available on wards. This ensured that staff were able to respect the traditions of different faiths at the time of death.

- There was a special viewing room in the mortuary where relatives could spend time with a deceased patient. Mortuary staff also contacted the chaplaincy in cases where relatives required additional emotional support.

- Mortuary viewing facilities were appropriate and allowed relatives privacy. The room was appropriately decorated and staff were available to answer questions and signpost relatives to appropriate people if they had further queries.

- Mortuary staff purchased special crib cots and clothing to dress a deceased baby when parents and relatives came to view them. They also bought special cooling trays to ensure that the body was kept at an ambient temperature during the viewing process.

- Mortuary staff made special headrests to ensure that the deceased was positioned so that their head would not slide sideways during viewing. They had also developed magnetic fridge disks to be placed on mortuary fridges to alert staff that the deceased may have implants that needed to be removed.

- Next to the chapel was a small multi-faith room that was used by Muslim patients and relatives for prayers. There was information in this room about daily afternoon and evening congregational prayers and Friday prayers. Items for prayers were also made available. We spoke with three relatives and two patients who told us they found the availability of this room helpful to meeting their needs.

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Learning from complaints and concerns

- Throughout the hospital, there was information for patients on how to raise concerns and complaints. Patients and relatives we spoke with knew how to raise concerns and make complaints if they needed to.
- The hospital palliative care team had received no complaints from relatives regarding end of life care.
- The trust had started to analyse all complaints from January to December 2014 to ascertain if any related to end of life care. They told us that this would help them check whether any learning from complaints could be shared across the trust. The work on this had not yet been completed.

Are end of life care services well-led?

Good ●

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

The trust had recently revised its end of life care strategy based on national guidance. Both the end of life care team and the hospital specialist palliative care team contributed to this strategy. The trust end of life care steering group had recently been relaunched to monitor performance against national standards. There was governance arrangements to monitor quality, although risks in end of life care were not sufficiently recorded and reviewed on risk registers. The service was aware of its problems, however, and these were being addressed or escalated. The service was led by a consultant in palliative care and nurse specialists who championed the end of life and palliative care. The leadership of the service was seen as visible and effective. The trust had only recently appointed a board lead; the change had yet to have an impact, but it was seen as positive and likely to quicken the pace of service development across the trust.

Staff working in the trust were motivated to provide good end of life care and the service was effective and supportive to staff, patients and relatives. The trust had made

improvements in engaging with the public, and had plans to involve relatives in the end of life steering group. The service had plans to innovate and improve the care and effectiveness of services.

Vision and strategy for this service

- The trust's clinical strategy for end of life care was rewritten after the national withdrawal of the Liverpool Care Pathway in July 2014. The revised strategy took account of the national guidance and other documents such as the latest National Institute for Health and Care Excellence (NICE) guidance. The strategy outlined how end of life care would be structured by the roles and responsibilities of the end of life care facilitators and the hospital palliative care team. It had yet to be rolled out across the trust.
- The hospital palliative care and end of life care teams understood the priorities for end of life care services. These priorities were widely shared across the organisation.
- Both the trust palliative care team and the end of life care team showed passion and commitment to providing good end of life care. The teams had identified the lack of resources in the end of life care services, including medical staffing. End of life care facilitators had been secured until March 2016. The trust was one of seven national Department of Health pilot sites for the palliative care funding review. The vision for the service was to provide high-quality end of life and palliative care across the acute and community service, and to ensure that the services were appropriately resourced.

Governance, risk management and quality measurement

- The trust had relaunched its end of life steering group. The purpose of this group was to bring together all the various staff working in end of life care so as to ensure that there clear identifiable objectives for end of life against national standards. The first meeting took place in January 2015.
- There were audit systems to monitor the quality of the service (for example, the response to the National Care of the Dying Audit – Hospitals (NCDAH) 2013/14 and the use of the 'Do not attempt cardiopulmonary resuscitation' [DNACPR] forms). These systems needed to be further embedded to demonstrate that actions or new initiatives were improving end of life care.

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- The hospital palliative care team had regular team meetings in which the team discussed patient care and how well the department was performing in meeting various targets. These meetings were held once a week and were well attended by the team.
- The service did not have a specific risk register and risk registers for the divisions, or the corporate risk register, did not include all areas of risk in end of life care. For example, the lack of side rooms was identified in surgery but the withdrawal of the Liverpool Care Pathway and subsequent care plans was not identified as a risk.

Leadership of this service

- The director of nursing was the board lead with responsibility for end of life care services in the trust. This had been a recent development (October 2014) and it was too early to assess its impact. However, senior staff told us that having a lead on the trust board had been well received and there was now a push to get this agenda firmly embedded across the trust.
- The service was led by the consultant in palliative care who championed the cause of end of life and palliative care. They had brought various groups of staff together to ensure that the patient experience was positive. Doctors and nurses on the wards told us that the consultant was very visible and that the wider team of clinical nurse specialists, end of life care facilitators, chaplaincy workers, bereavement support staff and mortuary staff translated compassionate care into reality. It was through passion, drive and motivation that the consultant had enabled the wider team to champion the cause.

Culture within this service

- Staff across the trust wanted to provide good care to patients and support to relatives whose loved ones were at the end of life. They worked well individually and collectively across the trust to make the patient journey the best they could. They were proud of the work they did and we saw the commitment they had.
- Relatives and ward staff told us that the palliative care team, end of life care team, bereavement support staff, chaplains and the mortuary staff knew what was needed to make a the difference in the lives of the patients and their relatives. They went out of their way to be unique so as to make a difference. For example, the bereavement support staff helped relatives with the planning of funerals.

Public and staff engagement

- The action plan following the NCDAH 2013/14 was closely monitored and we saw the improvement the service had made across the 17 national organisational and clinical performance indicators. For example, there were ward assessments on the nutrition and hydration status of end of life care patients. The links made with local faith communities by the chaplaincy team and the palliative care consultant enabled greater understanding of how the various faiths could support the work of the trust in this area. For example, leaders from the faith communities volunteered at the trust. The trust also linked in with interfaith week every year because this helped take the message of end of life care to the wider community.
- The listening exercise led by the chaplaincy team with staff groups identified what compassionate care looked like. Over 600 staff attended the various consultation programmes led by the team. This work fed into the overall end of life draft strategy to be implemented across the trust.
- The trust invited bereaved relatives to meet the chief executive officer. While this strategy was not so successful, with low numbers coming to the event, the trust continued to engage with relatives and to learn from their experiences. There were plans to consult relatives on the end of life care strategy.

Innovation, improvement and sustainability

- The trust had plans to introduce a 'Spiritual care competency passport' and an 'End of life care competency framework' in 2014/15 to enable staff to provide more support and care to patients and relatives across the trust.
- There were also plans to introduce Schwartz Centre Rounds to staff in 2015/16 so that they could explore together some of the challenging psychosocial and emotional issues that arise from caring for patients. Schwartz Rounds are meetings which provide an opportunity for staff from
- There were plans to roll out the Electronic Palliative Care Coordinating System (EPaCCS), which would help measure the effectiveness of palliative care services. The EPaCCS system is a community based system used by GPs.

- Senior members of the department told us that the trust was assured of funding to sustain and improve the service because the local commissioning groups were working with them to ensure high quality of service for end of life care.

Outpatients and diagnostic imaging

Safe	**Requires improvement**	🟠
Effective		
Caring	**Good**	🟢
Responsive	**Requires improvement**	🟠
Well-led	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

The University Hospital Southampton NHS Foundation Trust provides outpatient appointments and diagnostic services for a wide range of specialties, including medical, surgical and ophthalmology. The trust operates outpatient clinics from two sites: Southampton General Hospital and Royal South Hants Hospital, the latter providing ear, nose and throat (ENT), trauma, orthopaedic and dermatology specialties. The trust is also a regional cancer centre. The adults' outpatient department provided 48,542 new appointments and 372,162 follow-up appointments in 2013/14.

Diagnostic imaging services are provided on both sites. They offer patients magnetic resonance imaging (MRI), computerised tomography (CT) scanning, ultrasound and x-rays. There are other diagnostic services provided by the trust. These include echocardiogram (ECG) and phlebotomy.

Outpatient appointments are available Monday to Friday between 9am and 5pm, with some clinics held in the evenings and Saturday mornings to reduce waiting times. Patients can make appointments with the patient service centre until 8pm Monday to Friday and on Saturday mornings.

During two separate visits, we inspected ophthalmology, respiratory, neurology, ENT, trauma, orthopaedics, rheumatology and cardiology, and we spoke to patients and staff involved with oncology outpatient services. In total, we spoke with 54 patients and 67 members of staff, including nurses, consultants and other medical staff, radiographers, physiotherapists, healthcare assistants, administrators, receptionists and managers.

Throughout the inspection we reviewed trust policies and procedures, staff training records, audits and performance data. We also looked at computerised records and online booking systems, and we attended focus groups and listening events. We observed care being provided.

Outpatients and diagnostic imaging

Summary of findings

Outpatient staff showed a good understanding about reporting incidents. Learning was shared within specialties but not across the outpatient department as a whole. In diagnostic imaging, there was less consistent reporting of incidents. Incidents under the ionising radiation medical exposure regulation (IR(ME)R) had been reported to the Care Quality Commission. Patients had been told but formal procedures to inform patients under the Duty of Candour had not been followed.

Diagnostic imaging services had been developed to cover 24 hours, 7 days a week working. Whilst additional budget had been agreed for this service expansion, all the necessary additional staff had not yet been recruited. Radiographers were working overtime and were under pressure to meet the demands of the new rota. This was having an impact on safety with staff working long hours, working alone (which was contrary to policy) and new staff working alongside staff who were also inexperienced. Staff reported that the number of mistakes was increasing.

All safeguarding and mandatory training was up to date, and nurses in outpatient clinics had good understanding of safeguarding procedures. Outpatient clinic staff trust-wide showed a very good understanding of assisting patients who had dementia or a learning disability.

In the respiratory centre, the allergy clinic demonstrated outstanding practice and had been given a World Health Organization (WHO) award for excellence.

In ophthalmology and ear, nose and throat (ENT), some extra clinics had been scheduled for Saturday mornings to reduce waiting lists and accommodate patients who could not attend during the week.

Patients told us that they felt well cared for and informed about their treatment by compassionate staff, and this care was extended to relatives.

The trust was not meeting the national referral to treatment target time for 95% of patients to be referred and treated within 18 weeks for outpatient services.

Waiting times for patients upon arrival in the outpatient clinics varied. Some patients could wait several hours to be seen in some clinics, and were warned in advance of this possibility.

The trust was not meeting the cancer waiting time target for referral to definitive treatment within 62 days

In diagnostics, the trust was performing better than the England average in seeing patients within 6 weeks.

The trust had implemented a new interpreter service to accommodate patients whose first language was not English. However, there did not appear to be any signage or information leaflets available in other languages.

The NHS staff survey 2013 revealed difficulties in relation to the culture and leadership of the service, improvements could be seen in the 2014 survey. Mandatory training was up to date for radiographers but there was little opportunity for professional development. Radiographer staffing levels were of concern and having an impact on the safety of the service.

Staff felt supported by their immediate line management, but senior management teams were inaccessible to most staff. This was the case in both outpatient departments and diagnostic imaging.

A Commissioning for Quality and Innovation (CQUIN) project was initiated to reduce the number of new to follow-up patient appointments and improve performance within outpatient departments

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement ●

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

At the announced inspection in December 2014, some resuscitation trolleys had out-of-date equipment despite daily checks having been completed, and some trolleys were not checked daily. At the unannounced inspection in January 2015, the resuscitation trolleys were all in order. Medicines were appropriately managed. However, in the ophthalmology department a healthcare assistant was administering eye drops prescribed under a patient group direction. This was contrary to national guidance.

The imaging department had vacant posts for radiographers. Recruitment was ongoing but proving difficult and the trust was considering recruiting radiographers from abroad. Diagnostic imaging services had been developed to provide cover 24 hours, 7 days a week. However, there has been no increases in staffing, and radiographers were under pressure to meet the demands of the new rota. This was having an impacting on safety with staff working long hours, working alone (which was contrary to policy) and new staff working alongside staff who were also inexperienced. Staff reported that the number of mistakes was increasing.

The department had a radiation exposure hazard because a gamma camera was situated outside the nuclear medicine department, The trust had risk assessed this situation and short-term actions had been taken to mitigate the potential risk. It recognised that further action would need to be taken as a priority.

In the imaging department, staff were reporting some incidents but not all, because of work pressures and insufficient time. The trust had reported 22 reportable incidents in 2014 to the Care Quality Commission (CQC) ionising radiation medical exposure regulations (IR(ME)R) team. The trust was identified as a good reporter in terms of reporting, investigation and lessons learned. However, the trust reported a significantly high number of notifications when compared to other trusts. Although it

should be noted that trusts use different definitions of what to report under the IR(ME)R guidelines. The trust reported that all patients had been informed, but the department could not demonstrate that clear processes were followed under the duty of candour.

Outpatient staff throughout the trust reported incidents and received feedback when an incident had been investigated. Learning was shared within specialties but not across the outpatients department as a whole. Outpatient staff had good knowledge about the Duty of Candour when notifiable patient safety issues needed to be discussed the patients and recorded. The outpatient clinics were visibly clean and staff followed infection control practices. Consultant medical staff were appropriately available for clinics but some outpatient specialties had vacancies for nursing staff. Recruitment had begun to fill these posts. All mandatory training was up to date.

Incidents

- There were two serious incidents requiring investigation reported for outpatients and diagnostics in 2013/14. One was a fall that led to a fracture and the other a venous thromboembolism (VTE). Learning was shared in relation to these incidents and risk assessments completed to prevent reoccurrence. In cardiology, where one incident occurred, practice had been changed to follow National Institute for Health and Care Excellence (NICE) guidelines.

- The outpatient department staff told us they reported incidents using the trust's electronic reporting system. There was clear evidence of feedback from incidents being disseminated among all clinic staff and learning shared to improve patient outcomes. For example, as a result of an incident of corneal damage in the ophthalmology service, all departmental processes in relation to the incident were reviewed and staff competencies re-evaluated. The incident was discussed as a team in handover and the infection control specialist nurse was brought into the department to look specifically at decontamination of all eye equipment. New internal audits were being undertaken to monitor the cleanliness of equipment. Evidence of these audits was seen during the inspection.

- There was insufficient evidence to confirm that learning from incidents was trust wide. Feedback was generally kept within each care group service.

Outpatients and diagnostic imaging

- In the imaging department, there were several different types of radiation incidents reported that could have resulted in radiation exposure to patients: operational error (mainly by radiography staff), referral errors and 'near miss' incidents.
- Radiographers reported incidents to the trust's radiation protection team that protected people and the environment from the potential hazards of ionising radiation. The radiographers said that the incidents were increasing because of the pressures of low staffing numbers, lack of experienced staff and current shift patterns. Radiation protection staff told us that the radiographers were good at picking up incidents, but that fewer incidents had been reported on the new electronic system than previously when the paper system had been in place.
- Incidents involved patients not being identified correctly when arriving for imaging appointments, and diagnostics being carried out on the wrong patient, or the wrong limb. There were two reasons for this. First, patients did not always wear identification wristbands and were not always able to confirm their identity. At our unannounced inspection in January 2015, the service had taken steps to ensure that patients attending for imaging diagnostics wore an identification wristband to prevent such incidents. The second reason was the implementation of the new electronic referral system. Staff told us that doctors were repeating requests for x-rays , and these were not always identified by radiography staff. This led to patients being given two doses of radiation instead of one because imaging was repeated.
- Reportable incidents around ionising radiation medical exposure need to be reported to the CQC under (IR(ME)R). The trust had reported 22 reportable incidents between 1 January 2014 and 11 December 2014 and these had all been reported to the CQC. The IR(ME)R team had identified the trust as a good reporter in terms of reporting, investigation and lessons learned. However, the trust reported a significantly high number of notifications when compared to other trusts. Although it should be noted that trusts use different definitions of what to report under the IR(ME)R guidelines.

Duty of Candour

- In other outpatient departments including diagnostic imaging, staff were aware of Duty of Candour. There was access to e-learning across the departments. Staff knew whom to contact and where to find information relating to Duty of Candour.
- Staff showed that they were open and transparent with patients in the outpatient department. For example, after an incident of corneal damage during treatment, the patient was informed immediately of the incident.
- In the imaging department, there had been five reportable IR(ME)R incidents after 27 November 2014 (when the new legislation was enacted). The trust had notified us that the patients had been informed of the incidents. There was no evidence, however that the patients had been informed under the Duty of Candour, by senior staff, with written information and appropriate support.

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic areas were visibly clean and tidy. 'I am clean' stickers were present and in date on each piece of equipment checked.
- There was personal protective equipment available and hand-washing facilities in each clinical room. Staff across outpatients and diagnostic imaging were seen to be using the personal protective equipment appropriately.
- All staff across outpatients and diagnostic imaging had completed mandatory infection control training.
- In most outpatient departments, there was a clinician responsible for infection control and the cleanliness of the clinical areas. In ophthalmology, junior nursing staff and healthcare assistants worked alongside senior nursing colleagues for 3 months at a time to look at infection control and update the staff information folders when new policy information was sent through to the team. Hand gel was available in all communal areas, as well as in clinical rooms.
- There were posters in waiting areas and other communal areas advising patients to use hand gels.
- Ward noticeboards displayed outcomes of infection control and hand hygiene audits. These showed that compliance across outpatient services was between 97 and 100%.
- During our inspection, we observed correct systems for waste disposal, and waste bins being emptied and not overflowing.

Outpatients and diagnostic imaging

Environment and equipment

- In the outpatient departments, the environment was clean and well maintained. There was adequate room for patients to sit and wait for appointments. The consulting rooms and waiting areas were all wheelchair accessible.
- In the imaging department, the environment was well maintained and was wheelchair accessible. There was signage to alert patients to potential radiation hazards in relevant areas. There was adequate room for patients to sit and wait for appointments.
- There was a potential radiation exposure hazard from the positioning of a gamma camera outside the main nuclear medicine department. This meant that either radioactive material (isotopes) needed to be transported across a busy, public corridor, or patients injected with isotopes had to be taken across to where the gamma camera was situated. The trust had risk assessed this issue and taken steps to mitigate it in the short term (for example, with contamination monitors and clear procedures for staff to follow). However, staff told us of a significant increase in radiation isotope therapy without an increase in staff to meet the demand of the increasing workload. Existing staff felt that they were just managing, but were concerned about the risks of unsafe practice as a result. The service management told us they had escalated the department design risk to trust management but they did not have plans or timescales for its resolution.
- Daily checks of the resuscitation trolleys were completed on most trolleys. At the inspection in December, there were some items out of date in some outpatient clinics, despite their having been checked. Some equipment was out of date by more than a year. We brought this to the attention of the service. At our unannounced inspection in January 2015, the same trolleys were checked and all equipment was in date.
- The portable appliance testing on all 30 items we looked at were in date, and the equipment appeared in good condition.

Medicines

- All medicine cupboards were locked in accordance with trust policy and drug fridges were checked. Fridge temperatures were checked daily and in line with national guidance.
- FP10 prescription pads were stored securely.

- In the ophthalmology clinic, a healthcare assistant was observed administering eye drops that had been prescribed under a patient group direction. While the trust had a policy that allowed healthcare assistants to administer medication, this went against the patient group direction, NICE medical practice guideline 2 (2013)

Records

- Some outpatient clinics were 'paper light' when patient records were all online. Nursing and medical staff welcomed this change because it prevented the loss of patient records that had occurred fairly frequently beforehand. The trauma and orthopaedic clinics were already paper light. All nursing staff that we spoke to felt the online system was of benefit to both patients and staff. The ear, nose and throat (ENT) clinics were currently going through the transition from paper to online record keeping. There was IT support during the changeover to ensure that the process ran smoothly.
- All records we reviewed during both inspections were completed to a good standard. Confidentiality was adhered to in relation to the storage of patient information.

Safeguarding

- All the staff that we spoke to from outpatients and diagnostic imaging had completed their mandatory level 2 safeguarding training. When children were seen in departments (for example, ENT), there was a member of clinical staff available who had completed level 3 paediatric safeguarding.
- All staff knew how to report a safeguarding concern and who to speak to within the trust for further advice if needed. Such people included safeguarding leads within each outpatient specialty and trust-wide leads whose details were available on the intranet.
- Most outpatient clinics and diagnostic areas had safeguarding folders to support staff with reporting a safeguarding concern.

Mandatory training

- All staff mandatory training was up to date including infection control, safeguarding and manual handling. There was evidence on this in online reports and paper documentation in staff files.

Assessing and responding to patient risk

Outpatients and diagnostic imaging

- All staff was clear of the procedure to follow should a patient become unwell while visiting an outpatient clinic or diagnostic imaging department.
- In the imaging department, there were no signs or posters to tell women who may be pregnant to inform the radiographer before their x-ray.

Nursing/radiography staffing

- Most outpatient clinics had at least one vacancy for a staff nurse, senior nurse or healthcare assistant. However, recruitment had been undertaken to fill these positions. While these vacancies were outstanding, the existing nursing complement worked extra shifts to meet the needs of the service.
- Staff shortages were more apparent in diagnostic imaging where the vacancy rate was 11% (July 2014). The staff skill mix was often neither effective nor safe, with new members of staff working with other inexperienced colleagues. The trust recognised that the recruitment of radiographers was proving difficult and they were now looking to recruit from Portugal.
- The imaging department had developed 7-day working. However, there had not been an increase in staffing. Radiographers told us that they felt under pressure to maintain the current 24/7 shift pattern. Many said that they had 14 consecutive working shifts in a row without a day off, because the staff shortages meant that during 'on call' shifts they were often called in to assist colleagues. Radiographers felt that mistakes were being made because staff were exhausted and morale was so low.
- Staff told us that radiographers were often working alone at night undertaking computerised tomography (CT) scans, which was against departmental policy. The imaging department management team was not aware that this was happening.

Medical staffing

- In most departments, nursing staff reported good levels of consultant cover for all clinics.
- Within diagnostic imaging, there were approximately 44 consultants divided into specialist areas. Consultants confirmed a good working relationship with junior doctors within the trust.

Major incident awareness and training

- Staff were aware of their roles and responsibilities during a major incident.

- The recent outbreak of norovirus within the trust had led to actions being taken and extra infection control procedures being followed.
- Staff had regular fire drills and one occurred during our inspection. The procedure was followed well and staff were clear about how best to protect patients should a fire occur.

Are outpatient and diagnostic imaging services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department.

The outpatient and diagnostic imaging departments adhered to national guidelines and used local guidelines to keep practice up to date. The respiratory centre allergy clinic was nationally recognised and was awarded the World Health Organization (WHO) award for excellence in allergy management in the UK in 2013.

Outpatients staff had access to training and were able to use these opportunities to develop professionally. There was clear evidence of annual appraisals and supervision for all nursing staff, with pathways for progression. All staff documentation was clear and concise.

Multidisciplinary meetings were held to coordinate care around the patient (for example, in cancer services).

Outpatient clinics were mainly Monday to Friday but ophthalmology and ear, nose and throat (ENT) held clinics on Saturdays and some evenings. Diagnostic services were provided 24 hours, 7 days a week.

Radiography staff did not have appropriate training for all the equipment they used and they had limited opportunities to develop professionally. Some training was available, but it was not always possible for them to take part in this because of staffing issues. The imaging service was provided seven days a week.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Outpatient services adhered to the relevant National Institute for Health and Care Excellence (NICE) guidelines to treat patients. We looked at the clinical guidance for respiratory and rheumatology services, and in both cases it came from NICE.
- Research and specialist nurses kept outpatient staff up to date with all relevant local and national guidelines for each specialty.
- The respiratory centre allergy clinic is nationally recognised and often visited by other trusts for benchmarking. In 2013 the clinic was awarded the WHO award for excellence in allergy for the UK. The award will be kept for four years.
- Radiography staff told us that Royal College of Radiologist guidelines were not always followed with regard to obtaining a renal function test for patients before they were given contrast. They said that this was a clinical decision, but one that may not have always been recorded accurately.

Patient outcomes

- There were examples of participation in national audits. For example, the rheumatology department was involved in the National Clinical Audit for Rheumatology and Early Inflammatory Arthritis (BSR H Q1P) and the Arthritis and Musculoskeletal Alliance (ARMA) standards for rheumatology 2014 audits.

Competent staff

- We were shown documentation that confirmed that all nursing and support staff had received an annual appraisal.
- Nursing staff, healthcare assistants and administrators from each outpatient specialty were offered training opportunities to develop professionally and gain the latest skills and knowledge relevant to their post. However, it was sometimes difficult for staff to be released for training because of staffing shortages.
- Radiographers told us that they were unable to develop professionally because there was little opportunity. If they could secure any training, it was often difficult to be released to attend because of the low staffing levels.
- Radiographers also said that training in using a new scanner had not always been adequate, and they did not feel confident using the equipment.

- All staff felt confident about looking after a patient with dementia or a learning disability. The learning disability specialist nurse and her team were widely known throughout the hospital. They offered nurses and other clinicians training and information as required.
- Some nurses were aware of the need for revalidation and what their responsibilities were. Most said that they had not received any formal updates from the trust, but took their own initiative to ensure that they met requirements.

Multidisciplinary working

- In cancer services, staff told us that the multidisciplinary team worked well. It was well supported by a number of specialties including surgery, oncology and radiology. The meetings were arranged by a multidisciplinary team coordinator.
- Staff in outpatient clinics, such as neurology, trauma and orthopaedics, felt that they had good working relationships with all their colleagues including consultants, physiotherapists and radiographers.
- Radiographers told us that they did not always feel supported by their medical colleagues. It was felt that there was no recognition as to how staffing levels affected their day-to-day workloads.

Seven-day services

- Outpatient appointments were available Monday to Friday between 9am and 5pm. Some specialties offered appointments later in the evening but this was not standard practice across outpatients as a whole.
- Diagnostic imaging was a 7-day service with some outpatient scans being offered as late in the evening as 9pm. A radiologist was on call 24 hours.
- There were some Saturday clinics in ENT and ophthalmology to reduce waiting times.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Some staff had received training and could explain in comprehensive terms how the legislation affected their patients and what their responsibilities as staff were.

Outpatients and diagnostic imaging

- In neurology, nursing and medical staff gave a good example of interrupting an outpatient appointment when it was not clear that consent could be given by the patient in relation to their treatment.
- All staff knew whom to contact for any guidance in relation to the MCA or DoLS.

Are outpatient and diagnostic imaging services caring?

Good 🟢

By caring we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Patients were very happy with the care they had received in outpatients and diagnostic imaging. They consistently told us that they had been treated with kindness and compassion, and that staff took time to explain all aspects of their care. They also felt their privacy and dignity were respected.

Most patients felt well informed and consistently involved in the decision making about their care and treatment. Patients described how the emotional care and support provided to them was also extended to relatives who had accompanied them to appointments.

Compassionate care

- We observed care being provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments, staff were friendly, warm and professional, putting patients and their relatives at ease. Patients were treated with dignity and respect.
- We observed that parents and older people attending clinics or for procedures, were cared for with understanding and compassion. For example, one patient told us, "I've been coming here for 46 years; the staff have always been friendly and helpful." Another patient said, "The staff are lovely. I can't praise them highly enough."

- In all clinical areas, there was adequate provision to protect a patient's privacy and dignity. In diagnostic imaging, there were areas for patients to change into gowns and to remain there until their appointment.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.

Understanding and involvement of patients and those close to them

- Most patients felt well informed and involved in the decision making about their care and treatment from start to finish. For example, the relative of one patient with a long-term health condition said, "Our views have been included at all stages. We both feel involved in developing and monitoring the care plan. The staff at every level are caring and understanding. We are two very satisfied customers of the NHS!"
- Patients were aware of whom to contact if they were concerned about their appointments, and contact details were available on letters. However, patients were not informed if changes meant the doctor was not the one they usually saw.

Emotional support

- Patients commented that they had been well supported emotionally by staff. This was particularly so for those who had received bad news about their illness and had been distressed as a result.
- When interviewing staff, it was clear how passionate they were about caring for their patients and how they put patients' needs at the forefront of everything they did.
- The trust had a bereavement centre on site. The centre provided emotional support to relatives and supported relatives to make funeral arrangements.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 🟠

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as requires improvement.

The trust was not meeting the national referral to treatment target time for 95% of patients to be referred and

Outpatients and diagnostic imaging

treated within 18 weeks for outpatient services. Waiting times for patients upon arrival in the outpatient clinics varied. Some patients could wait several hours to be seen in some clinics, and were warned in advance of this possibility.

The trust was not meeting the cancer waiting time target for referral to definitive treatment within 62 days.

In diagnostic imaging there were delays at the weekend in neuroradiology reporting, resulting from undertaking interventional procedures. At weekends and bank holidays, the consultant neuroradiologist provided the reporting service. This mainly affected patients within the ED (emergency department) and inpatients within the trust. It impacted on patients undergoing CT and MRI scans at the weekend. Consultants were only able to book as many scans as they were able to report on, rather than booking to the availability of the scanner.

Many patients had received more than one letter for an appointment and each had a different time. This was confusing for patients, especially for those who then attended their clinic at the wrong time.

Patients experienced delays in some clinics, particularly in trauma, orthopaedics and ophthalmology where waiting times of up to 2 hours were common. We observed notices in reception areas, informing patients of the length of delay expected.

The ophthalmology department used colour-coded seating in the large, busy waiting area to guide patients through the department more easily.

In diagnostics, the trust was performing better than the England average and patients were being seen within 6 weeks. The trust was now meeting the waiting time target for urgent cancer appointments within 2 weeks, and the target for first definitive treatment for cancer within 31 days of diagnosis.

Outpatient services were managed by individual specialties. They had taken steps to meet patients' needs (for example, some clinics were held on Saturdays and in the evening after working hours). The patient service centre (the central booking office for most outpatient appointments) had also extended its opening hours to 8pm Monday to Friday and Saturday mornings.

Staff across outpatients and diagnostic imaging had a good understanding of how to make reasonable adjustments for patients with dementia or a learning disability. These included seeing these patients first on appointment lists .

The hospital had implemented an interpreter service. Staff with existing foreign language skills were encouraged to participate in a training programme to qualify as an interpreter.

Complaints were handled appropriately and there were improvements to services as a result. For example, in the ear, nose and throat (ENT) department at Royal South Hants Hospital, staff told us about changes made after patient feedback. Many patients said that they did not like using unisex toilets in the department. Consequently, new male and female toilets were built within the waiting area.

Service planning and delivery to meet the needs of local people

- Each outpatient department was managed within the division to which the specialty belonged, and the overall responsibility for that outpatient clinic was managed by the care group manager for that particular division.
- The patient service centre was responsible for booking all new outpatient appointments and most follow-up appointments. It had extended its opening times until 8pm in the evening, Monday to Friday, and also to Saturday mornings. This was to ensure that patients who wanted to book appointments could arrange them for when they got home from work.
- The performance of outpatient services was being improved. The new patient to follow up patient appointment were being addressed by a new project funded by local clinical commissioning groups (CCGs).

Access and flow

- The patient service centre had its own monthly targets to answer calls within 45 seconds. This was audited and results disseminated to team leads to inform plans to improve performance. The centre was meeting the 45-second target. Most patients said they did not have any difficulty getting through to the patient service centre to arrange or reschedule appointments.
- Twenty per cent of patients arranged their appointments under the NHS Choose and Book

Outpatients and diagnostic imaging

national electronic appointment system, which was lower than the national average. Appointments for the 2-week wait clinics, such as the cancer clinics, could not be arranged using Choose and Book.

- 'Did not attend (DNA)' rates for all clinics were below the national average of 7%, at around 6%. The trust policy for patients who did not attend clinic appointments was to discharge the patient. However, the patient's notes were first sent back to clinicians for the final decision to be made, so that patients with potentially serious illnesses were not discharged.

- There had been some short notice cancellations of clinics, particularly during December 2014 when the hospital had an outbreak of norovirus. Staff said it had been difficult to find appointments to rebook for patients (for example, when ENT nurse-led clinics had been cancelled because of staff sickness). Clinics were often booked up to 6 months in advance.

- National waiting times were for 95% of new patients to be offered an appointment and treatment with 18 weeks. We found waiting times for initial ophthalmology appointments to be 13 weeks. However, for all other specialties, the 18-week target for referral to outpatient treatment was not met (April 2013 to June 2014). The trust's performance then improved and during December 2014 most specialties met the 18-week target. Each week an 'incompletes' report was produced to keep track of patients on the 18-week pathway who had not yet been seen.

- Waiting times for patients on arrival in the outpatient clinics varied. Patients said they often waited a number of hours in the hospital to see the consultant or for diagnostics to be carried out. Staff confirmed that there were often delays. Some outpatient clinics kept patients informed of waiting times. For example, at Royal South Hants Hospital, there were notices by reception in the trauma and orthopaedic clinics informing patients of the potential waiting times.

- In ophthalmology, patients were given early appointments to ensure their visual acuity assessments were completed prior to medical consultation. Following this, patients then had to wait until 9am when their consultants were due to arrive. Staff told us that consultants were often late for clinics; therefore patients who were given earlier appointments were waiting up to

an hour following their visual acuity assessments to see their consultant. This delayed patients who had appointments scheduled for 9am onwards. Leading to clinics running late throughout the morning.

- In the ophthalmology waiting area, colour-coded seating had been introduced. The 'red, amber, green' seating enabled nursing staff to assess how many patients were waiting for a particular treatment or clinician within their large, busy department. Each colour represented an element of a patient's pathway. Senior nursing staff told us that this system worked well because staff could identify more quickly how many patients were waiting, for example, for visual acuity diagnostics or transport home.

- Over 2013/14, the trust had not met the two week cancer waiting time targets from referral from a GP to being seen by a specialist. During September to December 2014, the trust met this target Staff felt that difficulty in accessing timely diagnostics, such as a magnetic resonance imaging (MRI) or positron emission tomography (PET) scan, had caused delays previously.

- The trust also met the target for people waiting less than 31 days from diagnosis to first definitive treatment, although this was below the national average. The trust was not meeting the target for people to be waiting less than 62 days from referral to start of treatment. There was a detailed cancer recovery plan, which included seeking specialist external advice from the NHS Interim Management and Support Team

- Data from 2013 to early 2014 showed the trust was meeting the 31-day cancer waiting times but performance was below the national average. The target for people waiting fewer than 62 days from urgent GP referral to first definitive treatment was similar to, but had dropped below, the national average in 2014, and was not meeting the national target. The trust had a detailed cancer recovery plan and was working with the NHS Interim Management and Support (IMAS) team to implement external specialist advice.

- Data from April 2013–June 2014 showed that the trust had not been meeting targets for consultant-led treatment within 18 weeks of referral for incomplete pathways. Since August 2013, the percentage had improved and in March 2014 the trust was meeting the target of 92%, although this was below the national average of 94%. Staff in outpatient clinics told us that accessing diagnostic imaging had led to delays in patient pathways for most specialties, particularly when

patients were waiting for MRI or CT scans. At weekends, the number of CT and ultrasound scans that could be booked depended on how many the available radiologists would be able to report on (that is, not on the capacity of the equipment and radiography staff).

- Some outpatient clinics reported that often patients whom clinical staff were not expecting turned up for appointments, although the patients had letters confirming their appointments. We spoke to patients who had received up to three letters with different appointment times and dates.
- The patient service centre felt this could be due to Choose and Book appointments that the clinician, who reviewed patients' GP referral letters, changed for clinical reasons.
- One patient had been given an appointment later in the evening, when the clinic was not running.
- When patients arrived with letters for appointments that did not exist in the clinic, nurses regularly spoke with the consultant running the clinic to try and fit them in. Nursing staff across outpatients as a whole told us that consultants never turned patients away. This was responsive, but led to delays in clinic waiting times. The patient service centre could not say why this was occurring. As a result, 'Linking and liaising' meetings were held between the patient service centre manager and each specialty to try and improve systems.
- The respiratory centre allergy clinic was run by a senior registrar and a nurse. Up to three patients at a time are seen in clinic and are provided with specialist tests to identify food and drug allergies. The clinic has a very long waiting list influenced by the fact that they were awarded the World Health Organisation (WHO) award for excellence in allergy for the UK. The clinic accepts referrals from all over the UK, but particularly from the south of England.

Meeting people's individual needs

- All staff showed a good understanding of the need to make reasonable adjustments for patients requiring extra support. For example, if a patient, on arrival in the ophthalmology department, was assessed by a nurse as having a learning disability, dementia, or perhaps diabetes that was likely to have an impact on their experience within the department, a bright orange

'alert' card was placed in their notes. This ensured that they were seen more quickly within the department, and that nursing staff paid particular attention to them to ensure that their individual needs were met.

- Managers in the patient service centre stated that there was currently no system to identify a patient with a learning disability, so that the clinic could prepare by making reasonable adjustments before the patient's arrival (for example, by offering the patient the first appointment in the clinic list). However, the learning disability nurse told us that a flagging system to identify known patients was near completion.
- Neurology staff offered excellent examples of alternative arrangements whereby patients with dementia or a learning disability were able to wait in less formal areas of the hospital rather than a busy waiting area. Nursing staff telephoned the patient when their consultant was free so that they could return to the department and walk straight into the clinical room; this helped to reduce their anxiety. Staff also told us of an occasion when a consultant had seen a patient outside the department, in another hospital setting, because of the discomfort the patient felt in clinical areas.
- Translation services were widely available throughout the trust. The trust had set up a course, run in conjunction with Southampton University. Staff with existing foreign language skills could undertake a 5-day course with a final assessment to become a trust-wide translator. There was a diverse range of languages spoken in and around the Southampton area, and most of these were represented within the translator programme. This was a very responsive initiative, and staff involved in the programme enjoyed the learning experience.
- There was no evidence of leaflets or signage available in any other language or format.

Learning from complaints and concerns

- There was evidence that patient feedback was sought and welcomed across outpatient services. Comments cards were circulated and actively given to patients at the end of a clinic.
- Nursing staff gave good examples of learning from complaints and concerns, and genuinely viewed these as an opportunity for improvement.

Outpatients and diagnostic imaging

- In the ENT department at Royal South Hants Hospital, many comments were made by patients about having only one toilet for both men and women to use. The trust listened to this feedback and built separate toilets for men and women.

Are outpatient and diagnostic imaging services well-led?

Requires improvement ●

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as requires improvement.

There was no overall strategy for outpatient services, but improving capacity was identified across all specialties.

Morale was low among staff in diagnostic imaging and, although they felt supported by their immediate managers they were not confident that all their concerns, and the risks to quality and safety, were understood or being addressed by more senior managers.

Staff were familiar with the trust-wide vision and values and felt part of the trust as a whole. Outpatient staff told us that, while they felt supported by their immediate line managers, the senior management team were neither accessible nor visible within the department.

Staff at Southampton General Hospital identified a strong visible presence by the executive team, but this was not the same at Royal South Hants Hospital where staff recognised themselves as part of the trust but felt isolated corporately.

The relevant division managed the risk performance, quality and improvement for their own outpatient departments, although not all risks were accurately identified on risk registers. Regular governance meetings were held, and staff felt updated and involved in the outcomes of these meetings.

Three local clinical commissioning groups (CCGs) had approached the trust to set up a project to reduce the new to follow-up appointment ratio. The trust had worked

alongside the CCGs to ensure that the specialties chosen in the first instance were those that needed support to improve this target. This was planned as an ongoing project.

Vision and strategy for this service

- Staff were clear about the trust-wide vision and values. They saw 'putting patients first' as the primary value and told us that they felt it was part of the culture of the trust.
- There was no overall strategy for the outpatient service. Most staff in outpatients and diagnostics felt that improving capacity was their greatest concern. Staff told us that they would be happy to participate in providing extended services during evenings and at weekends, but they would need to recruit extra staff to meet these demands. There were no plans to outline such prospective changes.

Governance, risk management and quality measurement

- Each division managed its outpatients service, and risk, quality and performance information ty was managed through divisional arrangements. Staff told us that the risks they were concerned about were accurately reflected on the risk register for their division. Outpatient issues fed into divisional governance meetings where incidents and risks were discussed .Staff received feedback from these meetings from their direct line managers. Each division had a performance monitoring framework, where indicators of quality and performance were identified. We saw some action plans in place to address gaps in quality.
- Not all outpatient issues were identified on risk registers. For example, the 2-week cancer waiting times were failing to meet national targets, but the action taken to improve performance was not clearly identified on risk registers.

Leadership of service

- All outpatient and imaging staff told us that their immediate line management support was very good. They felt that the bands 6 and 7 staff within the departments knew what was happening within their teams and contributed well to the day-to-day leadership of the service. However, there was some disparity between this level of management and the next tier of senior management.

Outpatients and diagnostic imaging

- Staff across outpatients did not feel that senior management had a visible presence or made a significant impact on the service and staff as individuals. This was particularly the case in diagnostic imaging, where staff felt that senior management did not appreciate how low morale was and how staff were struggling to work with the new rotas. We raised this concern with the trust.
- At the unannounced follow-up inspection in January 2015, staff told us that the radiographers were now have a 'morning huddle' to determine optimum staffing in the CT- and MRI-scanning departments, and that a working group had also been set up to look at staff rotas. However, there were still issues about radiographers working alone in these departments after 1am.
- The trust had responded by holding listening clinics for radiographers to attend, voice their concerns and suggest ways of improving morale. Staff felt that the clinics had not shown any improvement so far, but that "it was early days".
- Some band 7 staff spoke highly of the trust's leadership programme and leadership academy. One nurse told us that the trust had "really invested in leadership and management and developing staff".

Culture within the service

- From our observation, it was apparent that the culture throughout the service was very caring, not only for patients but in staff supporting each other. In diagnostic imaging, despite difficult staffing issues, many radiographers said that they remained with the trust because of the supportive relationships they had fostered with other team members, and the line management support from their immediate supervisors.
- In the respiratory centre, we obtained a copy of the 'Charter of compassion' that identified three important values upheld by staff to promote a compassionate culture within their department. They were: 'to be compassionate to ourselves, to be compassionate to each other and to be compassionate to our patients'. These values were evident from our observations during the inspection.
- On a corporate level, staff at Southampton General Hospital spoke very highly of the chief executive officer (CEO). They identified a shift in culture when she arrived at the trust. Staff also told us that it was her priority to put patients and staff first. By contrast, at Royal South Hants Hospital, many staff had never met the CEO and

had little involvement at a corporate level with the trust. They did, however, very much recognise themselves as part of the trust, and they were familiar with its vision and values.

Public and staff engagement

- In every department there was clear evidence of feedback cards for patients to use to voice their opinions. We observed nursing staff giving patients comments cards to complete if there was an issue with their appointment or time spent waiting in the outpatients department. A nurse was heard to say, "Please tell us about your experiences so that we can improve services for you in the future." Feedback was sought from patients throughout the outpatients and diagnostic imaging departments as part of everyday working practice.
- Staff were encouraged to complete the NHS staff survey and this was well supported. In diagnostic imaging, the 2013 survey revealed that 42% of all staff felt subjected to harassment or bullying in the workplace. The imaging staff survey results had been poor for 2 years running. There was no evidence to suggest that senior management had a clear understanding of why this was the case. They had suggested 'external sources' or 'the new shift pattern' (in relation to the new 24 hours, 7 days a week service) as being responsible. The trust management was concerned about the outcome of the staff survey for radiographers and was attempting to address the issues raised.
- As a result of the negative feedback, radiographers were given the opportunity to voice their concerns at listening clinics and through internal surveys Action plans to improve the working environment for radiographers were produced as a result, and staff survey results for 2014 showed improvement. But during the inspection staff told us they did not feel that changes had followed.
- Outpatient staff gave feedback to their immediate managers, but were not confident that their concerns would be acted on. In ophthalmology, staff had mentioned to senior managers on several occasions that consultants were starting morning clinics late, causing delays for patients who had appointments booked from 8.15 onwards and thus to the entire morning clinic schedule. These issues were never addressed and the difficulties with delays to patients continued.

Outpatients and diagnostic imaging

- Team meetings were sporadic but staff felt they received updates in a timely manner from their direct supervisors. Staff information folders were updated regularly with new policies and procedures.

Innovation, improvement and sustainability

- The trust had a Commissioning for Quality and Innovation (CQUIN) project with their commissioners that aimed to reduce the length of time a patient had to wait from a first appointment through to a follow-up appointment by establishing whether a consultant was the best person to see the patient at follow-up. The project looked at telephone consultation (when appropriate), nurse-led clinic appointments and appointments within the community, rather than in the hospital. Patients were consulted throughout the process as to whether they would be happy with these different types of follow-up rather than a consultant appointment.

- As part of the project, specialties were chosen in conjunction with the CCGs. The first specialties involved in the programme were ear, nose and throat (ENT), urology, trauma, orthopaedics and rheumatology. Feedback was given to clinicians throughout the process. They were consulted about establishing new, more effective patient pathways to sustain improvement and reduce waiting times.

- The project performance was measured by surveying every patient who attended an appointment within the chosen speciality for a 2-month period. Action plans were created following consultation with patients and clinicians, and a report was produced and presented to the CCG. This project is likely to continue with four new specialties being chosen for the next year.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The emergency department used a coloured name band scheme for patients, as a direct result of learning from investigating falls in the department. Staff would know, at a glance, which patients had specific requirements, such as a high risk of falls, because of the coloured, highly visible name bands.
- We observed outstanding care and compassion in critical care, and in children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care. We also observed examples of outstanding care, such as from reception staff in the emergency department, who, although busy and working under tremendous pressures, made considerable efforts to reassure, inform and direct people presenting to them.
- A vulnerable adults support team (VAST) was based in the emergency department, and worked across the inpatient and community areas to support and safeguard vulnerable adults from abuse and harm.
- The hospital had developed a specific post for 'lead consultant for out-of-hours' (work). This had led to more effective management of medical patients outside the working hours.
- Consultants involved with elderly patients worked on a locality-based model, and there were named consultants for patients belonging to each GP locality. This had helped to improve continuity of inpatient care, and communication with patients and families, and other healthcare services in the community. Patients found it beneficial because they saw the same consultant every time, and found it was easier to approach consultants should they need any advice.
- A new initiative of Interim Medical Examiner Group (IMEG) meetings had been introduced to rapidly review all deaths in the trust. The group included representation from bereavement care, pathology, the patient safety team, patient support services and senior clinicians. It was led by the associate medical director for safety. This has improved the quality of information on death certificates and the speed of

death certification, information to the Coroner, the communication with families regarding concerns, and the recognition and improvement of patient safety issues, as well as the need to raise awareness about reporting incidents.
- The trust used an automated text system to alert staff about vacant shifts that needed to be filled urgently.
- There is a strong ethos of quality improvement and innovation within the neurosurgical department, which includes the development of the first day case intracranial tumour surgery programme within the UK, which has since been adopted by other units nationally.
- The general intensive care unit (GICU) had introduced early mobilisation for ventilated patients and this had resulted in reducing length of stay.
- Guidance and a training package had been developed to support the managing of patients with challenging behaviour in the critical care setting.
- The 'Uncertainty, Safety or Stop' cultural initiative in the neuro intensive care unit (NICU) was credited with giving all staff permission to say 'I do not know how to do this, and I need help'. This had helped to improve patient safety.
- Consultants in the cardiac intensive care unit (CICU) arranged weekend meetings for bereaved families. Families were invited back to the unit to discuss their relative's treatment and death, in order for them to better understand the patient's journey and the reason why they did not survive.
- Patient profiles were obtained in the NICU to give staff insight into a patient's likes, dislikes and interests. This enabled staff to talk with the patient about subjects that would interest them, whether they were conscious or not.
- The paediatric day care unit included a nurse-led service where nurses had extended roles. These included prescribing medicines and discharging patients.
- To ensure children's voices were heard and acted upon, the day care unit had developed the 'Pants & Tops' initiative. Through this initiative, children were

invited to write down on templates what had been 'tops' or 'pants' about their hospital stay. Children who were very young, and were unable to write, could still provide feedback.

- The children and young people's service used play leaders and youth support workers as advocates for children and young people. The service had an ethos of compassionate care and peer support, and social events were actively encouraged for children and for the parents of children with cancer, and long-term or chronic diseases.

- The trust had implemented a 'Ready, Steady, Go' initiative to support young people through the transition from children's to adult services. Young people were involved in deciding when they were transferred.

- The chaplaincy team held a listening exercise with staff to help identify what compassionate care meant for staff working at the trust. The 10 key recommendations from this report were now being implemented across the organisation.

- The bereavement support team were involved in the co-ordination of tissue transplantation. They explained how families could get involved, and supported families through the tissue transplant process. As a result of this service, tissue transplant donation had increased by 300% (from 20 tissue donations in 2011, to 60 donations in 2013/14).

- The Allergy Clinic within the outpatients department, had received a World Health Organization (WHO) award for excellence.

Areas for improvement

Action the hospital MUST take to improve
The hospital MUST ensure that :

- Nurse staffing is consistently at safe levels, to meet the needs of patients at the time and support safe care.

- Equipment is regularly tested and maintained, and a record of these checks is kept.

- There are suitable environments to promote the safety, privacy and dignity of patients in the cardiac short stay ward, G8 ward and all critical care areas with level 1 patients.

- There is sufficient basic equipment in all departments, and timely provision of pressure relieving equipment, beds and cots.

- The access and flow of patients across the hospital is improved. Discharge is effectively planned and organised, and actions are taken to improve delayed transfer of care discharges.

- All wards have the required skill mix to ensure patients are adequately supported with competent staff.

- No risks are posed to patient safety in the event of electrical failures in critical care areas.

- All risks associated with the cramped environment in critical care areas are clearly identified and timely action is taken to address those risks.

- Overhead hoists in critical units are correctly positioned, and in working order so they can be used, as intended, for patient care.

- There is an effective process embedded into practice for alerting medical staff or the outreach nursing team in the event of patients deteriorating on the general wards.

- There is appropriate management of identified risks in the general intensive care unit.

- There is a definite plan to develop critical care services to meet the local and regional population health needs; this plan to include the provision of appropriate follow-up services.

- The specialist palliative care team reviews the level of medical consultant support.

- There are safe staffing levels in diagnostic imaging teams to prevent untoward safety incidents occurring.

- Incidents are reported by radiographers, and there is learning from all IR(ME)R and diagnostic imaging incidents, and processes for Duty of Candour are appropriately followed.

Action the hospital SHOULD take to improve
The hospital should ensure that :

Outstanding practice and areas for improvement

- All staff follow the trust's infection control policy and procedures, in particular hand hygiene.

- Avoidable pressure ulcers of all grades are reduced across the hospital.
- Medicines are stored securely across the hospital.

- Emergency Department staff use evidence-based protocols/care pathways for a fractured neck of femur (a common presenting injury in the elderly) and head injury.
- Patients who are readmitted to the hospital as a 'failed discharge' are effectively dealt with on arrival at the emergency department, and their details are always entered on the hospital system as soon as they arrive.
- The national and paediatric early warning score systems are used appropriately in children's services, so that patients who are at risk of deterioration are correctly escalated.
- The requirements of single sex accommodation are met in the acute medical unit and the cardiac short stay ward, and any breaches are monitored and reported, including when level 1 patients remain in critical care settings because of delayed discharges.

- Information leaflets and signs are available in other languages, in plain English and in easy-to-read formats.

- There are robust processes in place to meet the trust's allocated discharge times.

- There are robust arrangements to meet referral to treatment times, but capacity and patient safety within the hospital are adequately assessed, so that areas such as theatres and critical care services are not constantly 'running hot'.

- Patients admitted for elective surgery, who require critical care beds, should not be cared for lengthy periods of time in recovery areas while they are waiting for critical care beds to become available.

- There is a plan to provide compatible equipment across the critical care services, so infusions and monitoring do not have to be temporarily disconnected when patients are transferring between wards and units.

- There is a trust follow-up service for all patients who have been treated on the critical care units.

- Medical staffing in the neuro intensive care unit at night is monitored to ensure the safety of patients who need critical care treatment, including respiratory support.

- There is availability of CT scans out of hours, which does not have an adverse impact on patients being treated in the neuro intensive care unit.

- The multidisciplinary team is involved when planning the development and refurbishment of critical care areas, to ensure the new environment will be suitable to meet the needs of patients.

- Staff are fully engaged with the plans to develop the general intensive care unit.

- There is a suitable environment in the general intensive care unit to ensure safe treatment for bariatric patients.

- An assessment is completed in the general intensive care unit on the impact that the electronic patient records equipment will have on the environment.

- There is an out of hours referral process for critical care beds by the outreach team that results in swift admissions to critical care services, releasing the outreach team to attend to other deteriorating patients in the hospital.

- The dietician service is available for all patients, rather than just for patients who align to specialist areas of treatment.

- There is dedicated time for staff to attend essential meetings, such as governance meetings.

- The new end of life care strategy is implemented and embedded across the trust.

- Relatives are consulted on the end of life care strategy.

- All staff caring for dying patients undertake mandatory training in end of life care.

- There is continuous support for ward staff to implement end of life care for patients post March 2016, when the end of life facilitators' role comes to an end.

- There is a review of the provision for teenagers, to ensure that there are dedicated facilities to meet their needs in all areas and for all specialties.

Outstanding practice and areas for improvement

- All staff understand the level of safeguarding training required for their role and how this is delivered.

- The trust follows national guidance to test for pregnancy in females before surgery and radiology investigations, in children and young people services.

- All protocols are version-controlled, and include references to information that has been used to inform their development.

- There is a review of the provision of pre admission and assessment clinics for children and young people to help prepare the child and family, and ensure their needs can be safely met.

- The impact of the current environment on services and outcomes for children and young people is regularly reviewed, and immediate steps taken to address any concerns.

- Access to the children's operating department is secure at all times.
- The practice of nurses using patient group directions to produce a patient specific direction in ophthalmology, is reviewed in relation to the medicines legislation.

- The culture and leadership in diagnostic imaging is improved.

- Staff in diagnostic imaging are consulted and updated on improvements, particularly in relation to recruitment of staff and staff rotas.
- The potential radiation hazard, in relation to the positioning of the gamma camera outside the nuclear medicine department, is removed.

- Learning from incidents is shared across all outpatient specialties and all staff groups.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. · There were not effective process in operation for alerting critical care medical staff or outreach team, in the event of patients deteriorating on the general wards. · Patients were not consistently discharged from the hospital in a timely fashion. This, along with a high number of delayed discharges, was having an impact on access and flow of all patients across the hospital. This delayed patient care and treatment in the appropriate ward or department. Regulation 9- 1 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 Health and Social Care Act 2008(Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

Compliance actions

The provider did not have effective systems to regularly assess and monitor the quality of services provided.

· There were not robust and transparent reporting and learning from incidents occurring in diagnostic imaging services.

· There were not robust or timely plans in place to address the risks within the critical care services.

· There were insufficient monitoring and identification of risks, or actions to address a range of risks in diagnostic imaging services.

· Mixed-sex accommodation breaches were not appropriately identified, recorded and managed in order to eliminate in accordance with Department of Health Guidelines, on the cardiac short stay ward.

Regulation 10 (1) (a) (b) (2) (c) (i) (HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety and suitability of premises The registered person had not ensured that service users using the premises were protected from the risks associated with unsuitable premises. · The environments in the cardiac short stay ward, G8 ward, and some critical care units with level 1 patients, did not promote the safety, privacy and dignity of patients. · Interruptions to the electrical supply in the general intensive care unit, affecting lighting and the working of monitors, posed a risk to patient safety.

Compliance actions

· The cramped environment in some critical care units created risks for staff and patients.

Regulation 15 (a)(c)(i)(ii) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. The provider did not have suitable arrangements to protect patients and staff against the risk of unsafe equipment or the lack of availability of equipment · Not all equipment was regularly checked or PAT tested. · The hoists in some critical care areas were poorly positioned, or out of order, so could not be used as intended for patient care. · There were some delays in the supply of pressure relieving equipment, beds and cots, as demand was not being met by the external contractor. · There was an insufficient supply of some basic equipment in some departments and wards. Regulation 16 (1)(a)(2) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Staffing.

Compliance actions

This section is primarily information for the provider

The provider did not have suitable arrangements to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed.

· High levels of nurse vacancies were having an impact on consistency of staffing levels in line with safer staffing nursing guidance. Nursing staff were moved across wards to try to mitigate risks; however, this led to concerns about lack of relevant skills to meet the needs of patients in different specialties.

· Low staffing levels in diagnostic imaging services, in particular radiographers, was having an impact on safety.

· There was insufficient medical cover, particularly at consultant level, for end of life care services across the hospital.

Regulation 22) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20: Duty of Candour · The imaging department did not have procedures to demonstrate that the Duty of Candour was considered, implemented and followed for reportable incidents under IR(ME)R. Regulation 20 (1)(2)(3)(4) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.