

Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

Queen Alexandra Hospital
Trust Headquarters
F Level QAH
Southwick Hill Road
Cosham
Portsmouth
PO6 3LY
Tel: 02392 286000
Website: www.porthosp.nhs.uk

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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

Requires improvement



Medical care

Requires improvement



Surgery

Requires improvement



Critical care

Outstanding



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust provides a full range of elective and emergency medical and surgical services to a local community of approximately 675,000 people who live in Portsmouth city centre and the surrounding areas of South East Hampshire. It provides some tertiary services to a wider catchment of approximately two million people. The trust also provides specialist renal and transplantation services and is host to the largest of five Ministry of Defence Hospital Units in England. Ministry of Defence staff work alongside NHS staff in the trust but have a separate leadership command structure. The trust employs over 7,000 staff.

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances and over 429,000 outpatient attendances each year. There are 6,000 staff employed by the Trust and approximately a further 1,000 are employed by a provide provider in portering, cleaning, maintenance and catering services under a PFI arrangements. The trust has not yet applied for foundation status.

The trust provides outpatients services in community hospitals at Gosport War Memorial Hospital, Petersfield Community Hospital and St Mary's Hospital. Gosport War Memorial Hospital has a minor injuries unit, inpatient rehabilitation on Ark Royal Ward (16 beds) and the Blake Maternity Unit (six beds). Petersfield Community Hospital has inpatient rehabilitation on Cedar Ward (22 beds) and the Grange Maternity Unit (four beds). There are eight satellite renal dialysis services, with six across Hampshire, one in Salisbury (Wiltshire) and one in Bognor Regis (West Sussex).

We undertook this inspection of Portsmouth Hospital NHS Trust as part of our comprehensive inspection programme.

Services provided at Queen Alexandra Hospital include accident and emergency, medical care, surgery, critical care, maternity and gynaecological services, children and young people's services, end of life care, and outpatient and diagnostic services. These eight core services are always inspected by the Care Quality Commission (CQC) as part of its new approach to the comprehensive inspection of hospitals. The services provided in community hospitals are integrated into the trust clinical and management structures; we have incorporated these within the core service areas.

The inspection took place between 10 and 13 February 2015, with additional unannounced visits on 25 and 26 February and 2 March 2015. The full inspection team included CQC managers, inspectors and analysts, doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers.

Overall, we rated this trust as 'requires improvement'. We rated it 'outstanding' for providing caring services and 'good' for effective services, but the trust 'required improvement' for providing safe, responsive and well-led services.

We rated critical care services as 'outstanding'; maternity and gynaecology, care of children and young people and Outpatients and diagnostic imaging as 'good'. Urgent and emergency services, medical care, surgery, end of life care, as 'requires improvement'.

Our key findings were as follows:

Are services safe?

- Patients who arrived by ambulance at the emergency department (ED) were at risk of unsafe care and treatment. We served two warning notices to the trust requiring immediate improvement to be made to the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED.
- Patients were sometimes assessed according to the time that they arrived in the ED and not according to clinical need. Some patients with serious conditions waited over an hour to be clinically assessed, which meant that their condition was at risk of deteriorating. Many patients waited in corridors and in temporary bay areas. Patient in these areas and in the majors queue area were not adequately observed or monitored.

Summary of findings

- The trust had introduced an initial clinical assessment by a healthcare assistant to mitigate risks, but this was not in line with national clinical guidelines.
- The environment in the ED did not enhance patient safety. The ED had been extended and its majors treatment area and children's treatment area were now a considerable distance from the resuscitation room. Staff had to negotiate crowded public areas in order to gain access to the resuscitation room. Patients were in areas, some temporary, where there was no access to essential equipment or call bells, and there was no safe area to support patients with a mental health condition.
- Nurse staffing levels were regularly reviewed using an appropriate and recognised management tool. There were high vacancy levels across the hospital, notably in the ED, the medical elderly care wards and the surgical assessment unit, where staffing levels were not always met and there were insufficient staff for the number of patients and the complexity of their care and treatment needs. Staffing levels were reviewed on a shift-by-shift basis and according to individual nursing requirements. Staff were transferred across units on a shift basis to try to reduce risk, but this affected the availability of expertise and continuity of care in other areas. There was high use of internal bank and agency staff, particularly on night shifts. Agency staff received an induction and safety briefing on wards before beginning their shift.
- Midwifery staff ratio was an average of 1:29 which was in line with the England average. The maternity dashboard clinical scorecard showed that the ratio had varied from 1:27 to 1:33 over the past 10 months. This reflected the actual number of midwives to birth and did not include maternity support workers. The recommendations of the Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) that there should be an average midwife to birth ratio of 1:28. Midwives, however, were working flexibly and one to one care was being provided for women in labour and with additional staff or strategies were provided to ensure the safety of antenatal and postoperative care.
- The trust had higher numbers than the England average of consultant medical staff in post, although it was not meeting national recommendations for consultant presence in maternity and for consultant staffing in end of life care. The trust had fewer middle-grade doctors and junior doctors compared with the England average and their workload was high in some specialties. For example, surgery and consultants in the ED were being stretched in an unsustainable way to cover posts and ensure safe services.
- Medical patients who were in the ED overnight and those on non-medical wards (outliers) were not always reviewed by specialist doctors in a timely way.
- Most services had a culture of openness and transparency. Staff understood the principles of duty of candour, and information, guidance and training were available to support staff to understand and implement the requirement of being open when things go wrong.
- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, venous thromboembolism (blood clots), catheter-related urinary tract infections and falls. The information was monitored throughout the hospital and the results were displayed for the public in clinical areas. The prevalence of catheter-related urinary tract infections was consistently low but the incidence of pressure ulcers and falls had not reduced but was increasing. Some pressure ulcer incidents were deemed unavoidable. However, the trust had not met its own targets for reduction in pressure ulcers and falls. There was evidence of actions taken in response but this varied; for example, the falls care bundle was used on medical wards but this was not used consistently on surgical wards.
- Staff were reporting incidents and lessons were learnt and practice was changed as a result. On one surgical ward, however, staff were concerned that disciplinary action could be instigated unfairly for pressure ulcer incidents. The trust had said that staff may face disciplinary action if they failed to care for patients appropriately, but not if it was beyond their control. Recent hospital data, however, indicated a decrease in the reporting of pressure ulcers on this ward.

Summary of findings

- The wards were visibly clean, and infection control practices were followed. The trust infection rates for MRSA and Clostridium difficile were within an expected range and the trust had not had a norovirus outbreak for five years. However, infection control arrangements in the surgical high care unit did not meet professional guidelines.
- Items of necessary equipment such as pressure-relieving mattresses, blood pressure monitors and medication pumps were not always readily available for patients when required. This meant that patient care and treatment could be delayed or adversely affected. The cardiac arrest call bell system in the E level theatres did not identify the location in which an emergency took place.
- Medicines were stored safely. However, the staff on a unit designated as an escalation ward told us they sometimes ran out of essential medications and had to borrow them from another ward. As a result there were delays in the timely administration
- Patients whose condition might deteriorate were being identified through the use of the early warning score. The trust had an electronic monitoring system for patients and this was used effectively, for example for the critical care outreach team to prioritise patients. However, early warning scores were not being used as part of bed management allocations.
- Staff were not always aware of standardised protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness of patients for day case surgery
- Safeguarding processes to protect vulnerable adults, and children and young people were embedded across the hospital. There was a recent safeguarding policy and procedure, staff had attended appropriate training, and there was a culture of appropriate reporting.
- Staff were undertaking mandatory training and progress towards trust targets was good for many staff disciplines with the exception of medical staff where attendance rates were low.
- The completion of patient records varied in some areas it was very good and in some places information could be missing, and it was not clear if this was part of the electronic or paper record. New end of life care plans were being piloted in response to the national withdrawal of the Liverpool Care Pathway. However, where these care plans were not used, the documentation, of care was not appropriate to properly assess and make decisions about patient care and treatment. Do not attempt cardiopulmonary resuscitation forms were not always appropriately completed.

Are services effective?

- Services provided care and treatment in line with national best practice guidelines, and outcomes for patients were often better than average or improving. However, operating procedures in theatres needed updating and end of life care guidance needed to be further developed across the trust. The trust needed to improve the management of stroke patients and it was not meeting the target for 90% of stroke patients to be cared for in a stroke unit.
- There was good participation in national and local audit programmes, although the trust did not fully participate in the National Care of the Dying Audit – Hospitals 2013/14.
- Patient outcomes, as measured by national audits, were either better than or similar to the England average; where they were below the average they were improving. Each clinical service centre had a quality dashboard to monitor patient safety outcomes although these needed further development to focus on clinical outcomes.
- The trust's mortality rates were within the expected range.
- Patients received good pain relief, in particular after surgery, in critical care and in end of life care. There were some delays, however, for patients who had arrived by ambulance in the ED.
- Patients, particularly older patients, were supported to ensure their hydration and nutrition needs were met. Although there were areas of concern identified on ward E3 for all patients and in end of life care on the acute medical unit.
- Staff were supported to access training and there was evidence of staff appraisal, although clinical supervision for nursing staff was under developed.
- Staff worked in multidisciplinary teams to centre care around patients. Physiotherapists on medical wards told us that although they did see medical patients, they could not always provide sufficient therapy sessions for their individual requirements.

Summary of findings

- Discharge summaries giving GPs information on patient care were delayed. The trust was not meeting Department of Health standards for letters to be sent within 48 hours and there could be delays of up to two weeks. Renal outpatient letters were taking 35 days to be typed and sent to the patients' GP because the renal department had a separate IT system from the rest of the trust. This had caused significant delay in GPs receiving updated information regarding their patients' treatment.
- Seven-day consultant-led services were developed in all areas, with the exception of outpatient services. Support services such as imaging, pharmacy, physiotherapy and occupational therapy were also available seven days a week.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission.
- Critical care services demonstrated outstanding innovations in delivery of effective care, ensuring there were robust systems to deliver and monitor care to high standards by highly skilled staff.

Are services caring?

- The trust had a culture of compassionate care. Staff were caring and compassionate, and treated patients with dignity and respect. Many patients and relatives told us that although staff were very busy, they were supported with compassion, patience, dignity and respect, with time being given to the delivery of personalised care.
- Staff were responsive to patients' emotional care needs. Emotional care was also provided by the chaplaincy department and patients and relatives told us how much they valued this service, which had supported them at difficult times.
- We observed outstanding care and compassion in critical care, maternity and gynaecology and 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.
- Data from the NHS Friends and Family Test demonstrated that patients were satisfied with the care they received. Overall results were above the England average and the trust was in the top quarter of all trusts. Results were clearly displayed in ward areas.
- Patients' experiences of care were variable, however. There were concerns, particularly for patients on the surgical ward E3 where staff were busy and essential and timely personal care was not delivered and patient dignity and confidentiality was not always maintained. Some patients with end of life care needs on wards E3 and the acute medical unit did not always get the timely care the families thought necessary or appropriate, and care was sometimes given by relatives instead.

Are services responsive?

- The trust was not meeting national targets for the timely handover of patients from ambulances. The trust had not met the emergency access target for 95% of patients to be admitted, discharged or transferred from A&E within four hours since November 2013. There was no hospital-wide escalation response to overcrowding in the ED to improve flow in the hospital.
- Specialty teams were often delayed in seeing patients who had been in the ED overnight.
- Bed occupancy across the hospital was 92% (January 2014 to 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.
- Patients were not always admitted to wards according to their clinical needs and were being placed where beds became available. This meant that the necessary level of specialist expertise and experience may not always have been available to them.

Summary of findings

- Patients could be moved several times during their admission. This happened at night and for non-clinical reasons. The trust identified that older patients, patients with high dependency and acuity needs and end of life care patients should not be moved. However, older patients, including patients who were confused, or living with dementia and who may have had complex conditions, were being moved.
- Patient moves were tracked but the information was not used effectively at ward level. Some medical staff told us they did not always know where to find them and this could lead to a delay in treatment. Patients' relatives also told us that they had difficulty finding patients.
- The critical care unit experienced discharge delays out of hours and delays to admission because of pressure on beds in the hospital. The unit had taken action to mitigate risks and this included comprehensive discharge summaries and a retrieval team who care for patients on the ward while they waited for admission.
- The national referral to treatment time target for 90% of patients to have surgery within 18 weeks was not met overall, although this was a planned fail in agreement with commissioners to address patients on the waiting list. Targets were not achieved in general surgery, trauma and orthopaedics, urology and ENT. In relation to urology, the trust attributed delays to limited staffing capacity, which had led to the cancellation of over 200 elective surgeries and a reduction in the number of elective patients admitted.
- Capacity issues within the hospital resulted in elective procedures being cancelled. Some patients told us their operations had been cancelled several times; although the majority did go on to have their surgery within 28 days.
- The trust was meeting the cancer waiting time target for 93% of patients to have referral from a GP to see a specialist within two weeks. The trust was also meeting the target for 96% of patients to have diagnosis to definitive treatment within one month (31 days). The trust had also met the target for 85% of patients to be waiting less than two months (62 days) from referral to start of treatment from April 2014 to December 2014. However, the target had not been met in January 2015 to March 2015.
- The trust was meeting referral-to-treatment time targets for most outpatient specialities but there were long waiting times for patients attending colorectal clinics, back pain clinics and the gastroenterology clinic. There was evidence of action being taken to address the long waits.
- Patient had timely follow up outpatient appointments although there were patients waiting beyond their due date in colorectal surgery, orthopaedic and gastro specialities. Ophthalmology had a high number of patients with significant delays to follow-up and who were on an outpatients waiting list. This had been on the service risk register since 2009, but as a result of a serious incident requiring investigation that occurred as a result of this backlog, it was escalated to the trust risk register in April 2013. The waiting list had been reduced but the number of patients waiting was still significant.
- The trust was now meeting the diagnostic waiting time target after extending the service times.
- Discharge plans were expected to commence on admission but this varied across wards, as did planning around simple and complex discharges. There were some delays in discharging patients and patients told us they had to wait a considerable time (hours) for their medications to take home. A discharge lounge was available and was used appropriately. Patients were able to have food and drink while waiting for discharge.
- The trust had delayed transfers of care and national data showed the main causes of delayed transfers of care at this trust (which could prevent a patient from being discharged) included waiting for nursing home places, waiting for social care arrangements, and patient/family choice. The trust was working with its partners to alleviate this problem and data published by NHS England (December 2014 to January 2015) demonstrated that the trust had a comparatively smaller number of delayed discharges compared with other similar trusts.
- The integrated model which the trust maternity service runs (Nurture programme) allowed flexible use of staff to maintain 1:1 care in labour. This had kept women's denied choice of place of birth to a minimum.
- There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than the national average.
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. However, this was not the case for ambulance patients waiting in corridors in the emergency department and also for patients in the

Summary of findings

dialysis unit on the Isle of Wight. Patients attending for outpatient appointments had to walk through the dialysis unit where patients were receiving treatment in their beds to attend their consultations. In ophthalmology department at Queen Alexandra Hospital, patients receiving treatment (pupil dilation) were being treated in a room that was glass walled, enabling any person walking by to observe a patient being treated.

- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients with a learning disability. However, care for patients living with dementia varied. Training, assessment, the use of the dementia care bundle and making reasonable adjustments to reduce stress and anxiety, were being used but not consistently. In some areas the care needs of people living with dementia were not always met. Some areas demonstrated excellent examples of the care such as the 'memory lane' service on the elderly care wards. This was held once a week and included engaging patients in remembering their past times by means of music, games, reading material and communication.
- An interpreting service was available for people whose first language was not English and the service was used. All information for patients was only available in English. In radiology, easy-to-read leaflets were available for patients with a learning disability, where language style had been adjusted and pictures used to explain procedures. We did not see any other information in an easy-to-read format.
- Information from complaints was reviewed and acted on; although some patients told us they were not always given information about how to make a complaint.

Are services well-led?

- Many staff were committed to the values of the trust: 'best hospital, best people, best care'.
- Most services did not have a formal written strategy, although aspects of future plans could be verbalised by staff. Staff in the ED were not aware or confident that there were clear plans and strategies to address significant concerns in a timely way.
- Departmental strategies and vision were generally well understood, except in medicine where no discernible long-term strategy could be described by staff.
- Clinical governance arrangements were well developed to assess and manage the quality of service provision. However, better management of risks was needed. Not all risks were appropriately identified, escalated and mitigated across service areas. The pressures in the ED were long-term and significant risks to patients had not been appropriately managed.
- Many staff told us overall they had good support from the local clinical leaders, for example ward managers and consultant staff. However, there were concerns, including: the support from managers at senior levels, the capacity of managers in the ED, of some ward managers and the fragmentation of management in end of life care.
- Many staff commented on the visible and approachable presence of the chief executive officer.
- Staff were positive and proud to work for the trust; many staff had worked in the trust for their entire career. There was an open and honest culture and a strong sense of teamwork across most areas. However, there were a few areas of concern and these were identified as the lack of hospital support and clinical engagement for the pressures in ED, the lack of integrated working across clinical service centres, the concern by staff on one ward of being unfairly disciplined for pressure ulcer incidents in surgery and the dysfunction team working in the colorectal team.
- There were innovative approaches to patient and public engagement across services, which included survey, focus groups, consultation, committee representation and the use of social media.
- Staff engagement was good, and the latest staff survey showed significant improvement in key areas. The trust was in the top 20% of trusts for staff engagement. The Listening in Action programme was cited as a particular example of involving staff in improving the quality of their services.
- There was a strong and visible commitment to research and development.
- Innovative ideas and approaches to care were encouraged and supported, and the trust was the recipient of many awards, both national and international, for the excellence of some of its services.
- The leadership in the critical care unit was outstanding.

Summary of findings

We saw many areas of outstanding practice including:

- A 'Coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, provide peer support and education. Patients were also given information about support available in the community.
- There were good arrangements for meeting the needs of patients with a learning disability, particularly in theatres. The staff showed good awareness of the specialist support that patients with complex needs sometimes require. Staff used a specialist pain management tool for assessing pain levels in patients who could not verbally communicate their experiences of pain.
- The trust had developed bespoke safeguarding training modules to meet the specific needs of staff and their working environments. For example, there was safeguarding training specific to the issues identified for staff working in theatres and specific types of wards.
- The practice of daily safety briefings on the intensive care unit (ICU) ensured the whole multidisciplinary team was aware of potential risks to patients and the running of the unit.
- In the ICU there were innovative approaches to the development and use of IT systems and social media. Secure Facebook and Twitter accounts enabled staff to be updated about events affecting the running of the service. This included information about risks, potential risks and incidents. Electronic 'Watch out' screens in the unit displayed information about incidents and the unit's risk register. The education team advertised information about training opportunities on the education Twitter account.
- In the ICU, innovative electronic recording systems supported the effective assessment and monitoring of patients.
- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time and the outreach team to monitor patients on all wards and prioritise which patients they needed to attend to. This early warning system was developed in response to delayed care in deteriorating patients. Its adoption has saved over 400 deaths, and overall has reduced our mortality levels by 15%.
- Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.
- In most critical care services, beds are positioned to face into the ward. On some units beds were positioned so that conscious patients could look out of the window. Queen Alexandra Hospital's critical care unit had learnt that some patients were frightened when they could not see the ward and wanted to be able to see into the unit for reassurance. In response, the unit had equipment that could position beds at an angle so patients could see out of window as well as into the unit.
- In response to difficulties in recruiting middle-grade (registrar) doctors, the ICU in partnership with the University of Portsmouth was developing a two-year course in Advanced Critical Care Practice (ACCP). The planned outcome from this course was that Advanced Critical Care Practitioners would be employed in the unit to fulfil some of the medical tasks and release medical staff to do more complicated work. This was the first initiative of this kind in the UK.
- To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the ICU had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care team in the ED, before admission to the unit. The same practice was followed for patients requiring admission to the unit from the general wards.
- The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.
- The critical care unit had developed their own innovative website that included educational information and guidance documents. There was guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.

Summary of findings

- A perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation.
- There was a telephone scheme for women who had experienced complex or traumatic deliveries to talk about, and have a debrief conversation, with a midwife following their discharge. The outcomes from the conversations were used as part of the governance processes and this had demonstrated a reduction in the number of complaints.
- A mobile telephone application (app) had been developed by the trust and the Chair of the Midwife Liaison Committee together with women who used the services. The app provided information on choices of place of birth and was being developed to include additional information. The app won an award from NHS England in the excellence in people category and the service had also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- The multidisciplinary team in the children's and young people's services had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families. We found all staff, at all levels, were involved in working towards this goal and this was having a positive impact on improving the safety and quality of services for children, young people and their families.
- There was a new initiative called a 'talent panel', which was a mechanism to discover and develop staff, both for individual career development and the future sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified.
- The trust had introduced a volunteer programme for people who wanted to work as a chaplain's assistant. Volunteers were trained on how to support patients through visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust received a national award for clinical research impact. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients. The trust identified the development of the early warning system, mobile application for pregnant mothers (cited above), and developing methodologies to reduced respiratory exacerbations and admissions and detect upper and lower gastrointestinal cancer more effectively.

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

Importantly, the trust **must** ensure that:

- Patients are appropriately assessed and monitored in the ED to ensure they receive appropriate care and treatment.
- Ambulance patients are received and triaged in the ED by a qualified healthcare professional.
- There are effective system to identify, assess and manage the risks in the ED.
- There is an adequate supply of basic equipment and timely provision of pressure-relieving mattresses.
- The cardiac arrest call bell system in E level theatres is able to identify the location of the emergency.
- Medication is prescribed appropriately in surgery and is administered as prescribed in gynaecology
- The emergency resuscitation trolley on the gynaecology ward is appropriately checked.
- Appropriate standards of care are maintained on ward E3 and the acute medical unit.
- There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.
- Patients' bed moves are appropriately monitored and there is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night, several times and for non-clinical reasons.
- Patients are allocated to specialist wards, when clinical need requires this, and medical outliers are regularly reviewed by medical consultants.
- Nurse staffing levels comply with safer staffing levels guidance.
- There are adequate numbers of medical staff on shifts at all times.
- All wards have the required skill mix to ensure patients are adequately supported by competent staff.

Summary of findings

- Patients are risk-assessed before providing treatment for deep vein thrombosis.
- The falls action plans are followed in a consistent way across the medical services.
- There is compliance with the WHO Surgical Safety Checklist.
- Staff awareness of standard protocols or agreed indicators for pre-assessment improves to support them in making decisions about the appropriateness of patients for day case surgery.
- Staff on all wards are able to raise concerns above ward level, particularly when this impacts on patient care, and there is a response to these concerns.
- Discharge summaries are sent out in a timely manner and include all relevant information in line with Department of Health (2009) guidelines.
- Staff observe recognised professional hand hygiene standards at all times.
- The surgical high care unit is risk-assessed for infection control risks.
- Medical and dental staff complete mandatory and statutory training.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Nursing handovers provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.
- Nursing staff are appropriately trained in the safe use of syringe drivers.
- All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded.
- Patient confidentiality is protected so that patients and visitors cannot overhear confidential discussions about patients' care and treatment.
- Records are kept relating to the assessment and monitoring of deteriorating patients in recovery.
- Patient records and drug charts are complete and contain all required information relating to a patient's care and treatment.
- Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.
- Patient records are stored so that confidentiality is maintained.
- The trust fully participates in all national audits for which it is eligible on end of life care.
- Action is taken to improve the leadership where there are services and ward areas of concern.

In addition the trust **should** ensure that:

- Drugs trolleys are not left open or unsupervised in patient bay areas.
- Medicines reconciliation is based on one or more sources of information to determine which medicines an individual patient has been prescribed outside the hospital and still requires while in hospital.
- The 'This is me' booklet for patients living with dementia is used appropriately by staff.
- There is a 'flagging' system for identifying patients with a learning disability.
- Patients are able to take the medicines they are given and do not have problems opening medication packaging.
- Staff are aware of protocols for recording opening or expiry dates on part-used medicines.
- Pharmacists initial all changes to patient prescriptions.
- Staff in surgery understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Clinical governance arrangements include Ministry of Defence staff so these staff are aware of quality and safety issues when working on wards.
- The need for a dedicated dietician is reviewed on the ICU.
- Patient clinical details are recorded in a clear and consistent manner so that there is no risk of information being missed.
- Documentation regarding fluid intake and output, and intentional rounding, is appropriately completed to demonstrate that care is delivered.

Summary of findings

- The trust continues to review consultant cover on the obstetric consultant-led unit so that this is in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth (2007) recommendations.
- Physiotherapy services to patients on the consultant-led obstetric unit are reviewed so that patients do not experience delays in accessing physiotherapy care and treatment.
- An accredited acuity tool is used to accurately assess nurse staffing levels required to care for medical and high dependency patients on the wards.
- Security arrangements are sufficiently robust to avoid visitors 'tailgating' into the paediatric unit out of hours, or to gain access to the children's assessment unit.
- Protocols for the treatment of diabetic ketoacidosis for young people are standardised across the hospital.
- There are appropriate facilities for teenagers admitted to the wards, and accommodation is provided in bays with patients of a similar age.
- Access arrangements to the neonatal unit are sufficiently responsive out of hours when nursing staff are busy caring for neonates.
- Arrangements for psychological and emotional support for children and young people with non-acute mental health needs is reviewed.
- The bleep holder's folder contains current information that is clear to read and easy to find.
- Services have detailed strategic plans for service developments, for example, for the single point of access and appropriate provision of high dependency services.
- Action is taken on the workload of the bereavement support service in response to the external assessment undertaken by the local clinical commissioning group.
- Patient information is available in an easy-to-read format.
- Patients are given information about how to make a complaint and what responses they should expect to receive.
- There are end of life care link nurses on wards and the link nurses are given time and support to be the champions of end of life care.
- The layout of the ophthalmology outpatient department and location of visual acuity tests is reviewed so that patients' privacy and dignity is maintained during treatment.
- Patients attending for renal outpatient appointments on the Isle of Wight do not walk through the dialysis unit where patients are receiving treatment.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We have issued two warning notices because safety was inadequate in the emergency department (ED). Severe overcrowding meant that ambulance patients had to wait on trolleys in a corridor before being assessed and some patients with serious conditions had waited over an hour to be assessed. Patients were not appropriately monitored and observed while waiting in the corridor and there was a high risk of their condition deteriorating during this time.

The environment in the department did not enhance patient safety. The department had changed to accommodate more patients. However staff had to negotiate crowded public areas in order to gain access to the resuscitation room and staffing levels had not changed to take account of the increase in the number of patients. There was an over-reliance on agency nurses on late shifts and a lack of experienced doctors at night. Consultant staff were extending their working hours overnight and into early mornings to ensure safety, but this was not a sustainable practice.

Patients were in areas, including some temporary areas, where there was no access to essential equipment or call bells, and there was no safe area to support patients who may have a mental health condition. Once assessed, the early warning score was used to monitor patients whose condition might deteriorate, but this was not used to determine clinical need for admission to an inpatient bed. Patients were not being seen by a specialist doctor in a timely way if they had been in the department overnight.

Children had appropriate separate facilities within the department. Safeguarding was understood and protocols were followed. Staff were aware of safety issues and demonstrated that it was at the forefront of their thinking. Incidents were reported promptly and investigated appropriately. Learning from incidents was shared with staff and used to improve the service. Medicines and records were

Summary of findings

appropriately managed and infection control procedures were followed. The minor injuries unit at Gosport War Memorial Hospital followed appropriate practice standards.

Policies and procedures were developed in conjunction with national guidance and best practice evidence and the department undertook national and local audits. Pain relief was offered appropriately in most cases, and its effectiveness was assessed and acted on. Patients were offered food and drink.

Staff were competent and had undertaken appropriate specialist training. Multidisciplinary working was in evidence so that the needs of each patient were prioritised. Staff had a good understanding of consent and the Mental Capacity Act 2005.

The staff provided compassionate care and ensured that patients were treated with dignity and respect. We saw outstanding care being given to relatives in the resuscitation room. There were positive comments from patients about the care received and they and their relatives were kept informed of ongoing plans and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options. Play leaders in the children's treatment area provided distraction from potentially upsetting treatment such as injections and nebulisers.

There were large numbers of people arriving by ambulance and the flow of patients in the ED was often blocked by internal capacity issues in the hospital. The trust had not met the national emergency access target to admit, transfer or discharge 95% of patients within four hours of arrival since November 2013. It was not meeting the national target to receive and assess ambulance patients within 15 minutes of arrival. There was no adequate escalation plan to manage overcrowding in the ED and address these issues. There was no single point of access for children who need emergency care, as recommended by national guidelines.

Staff responded well to patients' individual needs. There was clear understanding of the requirements of people living with dementia or a learning

Summary of findings

disability. Relatives were encouraged to stay with them while in the department. Complaints were handled appropriately and the learning was used to improve services.

The department did not have a written strategy and appropriate actions had not been taken to reduce the risks associated with delays to patient treatment. Governance arrangements were monitoring risks and quality, and there was appropriate escalation of concerns. However, medical and nursing staff expressed a sense of isolation from the rest of the hospital and were unable to resolve problems with flow without hospital support. The department did not consider it had adequate levels of clinical leadership.

Staff told us that the ED had an open and honest culture and excellent teamwork. Medical leadership was constantly visible in the clinical environment. The matron and head of nursing worked across the ED and acute medical unit. The leadership team demonstrated the skills, knowledge and experience needed for their roles.

Medical care

Requires improvement



Medical care services required improvement in some aspects of patient safety, such as nursing staffing levels, 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 and these patients were not regularly reviewed by medical consultants. 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 care. Care was provided in line with national best practice guidelines. Arrangements were in place to ensure that staff 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 coordinated way. When 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. Patients and relatives we spoke with felt they were well informed

Summary of findings

and involved in the decision-making process regarding their treatment. Relatives felt they were fully informed about their family members' treatment and care.

The hospital experienced difficulty meeting the demand for its medical services. Patient moves were tracked by the trust. Although the frequency and reasons were not always appropriately monitored and patient moves were not monitored at ward level. 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 achieving the 31-day cancer waiting time diagnosis to treatment target. The trust was not meeting the 62-day referral-to-treatment target overall. However, the target was being met in medical specialties with the exception of respiratory speciality. Integrated pathways of care had been developed in a number of medical specialties. Pathways of care were continuing to be developed and reviewed in some areas, for example in care of elderly services. The medical clinical service centre did not have a long-term strategy but priorities were identified around improving the services. There were effective governance arrangements and staff felt supported by service centre and trust management. However, some risks were not well understood by leaders and plans to address these needed to improve. Better joined up working with other clinical service centres for example, surgery and emergency department were also identified as areas for improvement. The culture within medical services was caring and supportive. Staff were actively engaged and innovation and learning was supported. Staff from Cedar and Ark Royal wards told us that though they were located away from the main hospital, the trust leadership including the chief executive were visible on the ward.

Patients at Gostport War Memorial Hospital and Petersfield Community Hospital received effective care and treatment from caring staff. There was good local leadership of these services.

Surgery

Requires improvement



We found that while staff were compassionate and caring and outcomes for patients were generally

Summary of findings

above the England national average, improvements were required to ensure safe, responsive and well-led treatment and care for patients. Incidents were usually reported and learning from these was shared with staff. Overall standards of cleanliness were good, although there were exceptions in relation to hand hygiene practices on some of the wards we visited. Sufficient equipment was not always available to meet patients' needs.

The five steps to safer surgery checklist was completed but its documentation needed to improve. Electronic monitoring was used on surgical wards to identify patients at risk of deteriorating. However, staff in theatres did not consistently use an early warning tool to identify deteriorating patients.

Staff were not aware of standardised protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness of patients for day case surgery. There was a high uptake of mandatory and statutory training by nursing staff but trust records showed poor take up of this training by surgical and dental staff. Risks to patient care were identified and escalated but were not always resolved in a timely manner, particularly in relation to theatre facilities. There was a shortage of nursing staff across the service as well as a shortage of anaesthetic staff.

Emergency surgery was managed in line with national professional requirements. Clinical audit was used to monitor compliance with evidence-based national guidelines and best practice. Patients' needs were assessed, monitored and addressed. Patient outcomes against a number of indicators were better than the England national average. Mental capacity assessments were undertaken by surgical staff. However, ward staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were sometimes not enough beds for the number of patients requiring them. Patients were not always put on wards best suited to meeting their requirements for specialist treatment and care. The national referral to treatment time target for 90% of patients to have surgery within 18 weeks

Summary of findings

was not met overall, although this was a planned fail in agreement with Commissioners to address patients on the waiting list. Capacity issues within the hospital resulted in elective procedures being cancelled.

The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target. The trust was not meeting the 62-day referral-to-treatment target overall. The target was not being met in head and neck, lower GI and urology surgical specialties. There were clear clinical governance arrangements. Performance against operational and quality targets was monitored and action was taken when performance fell below expectations. Key risks were identified and escalated to the trust's risk register. However, staff across a number of wards raised concerns about not being able to escalate risks beyond ward level. Risk registers did not always identify how risks were being managed and many interventions were out of date. Staff were also concerned that disciplinary action was sometimes being instigated unfairly.

Critical care

Outstanding



There were many areas of outstanding and innovative practices in the critical care service. Innovative daily safety briefings and the use of secure social media informed staff about risk to patients, the running of the service and learning from incidents. The environment and equipment were well maintained. There were innovative and imaginative ways of storing equipment, which meant emergency equipment and information, could be accessed promptly when required. This included airway equipment and information for staff about what to do in the event of major incidents.

Electronic records supported the effective assessment and monitoring of patients. Electronic recording of patients' vital signs in the general hospital allowed the outreach team to remotely monitor deteriorating patients and prioritise which patients they attended to.

Staffing levels met patients' needs. Innovative practices and team working meant vacancies within

Summary of findings

the medical staff did not have an adverse impact on the wellbeing and safety of patients. This included consultants working in a registrar role to fill middle-grade vacancies.

There was a strong and effective education programme for nursing, medical and allied health professional staff. When possible, there was a multidisciplinary approach to education. In partnership with the University of Portsmouth, the unit was developing an Advanced Critical Care Practitioner course, the first in the UK. However, for trust-required mandatory and essential training, medical staff had not complied with the target set by the trust.

Feedback from patients and their relatives strongly indicated that there was a caring and supportive culture in the critical care unit.

The trust had the foresight to plan for the expansion of the service when designing and building the unit in 2009. There was capacity to expand the unit to 36 beds. National data showed that the unit performed worse than similar units for discharging patients to wards out of hours (between 10pm and 7am). The unit had taken action to mitigate any risk this posed, with the use of detailed discharge summaries, verbal handovers and ensuring all medicines had been administered before the patient is discharged.

Information for relatives and patients about the unit was available in leaflets and on the unit's own website. However, the information on the website was not easily accessible to people with a disability that made it difficult to read or understand written words.

To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the unit had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care retrieval team in the ED, before admission to the unit. This also happened for patients requiring admission to the unit from the general wards.

There was strong, supportive and effective leadership of the service. Staff were supported to

Summary of findings

develop leadership skills. The culture of leadership resulted in a no blame culture, where lessons were learnt from incidents and mistakes without blame being apportioned to staff.

Innovative ideas and approaches to care were encouraged and supported, many of which were enhancing patient safety and experience on the unit. This included the use of information technology and social media to enhance patient safety, the practice of daily safety briefings, the continued development of the electronic patient recording system, and the use of grab packs to give staff instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.

Maternity and gynaecology

Good



Patients who used the maternity and gynaecology services were protected from avoidable harm. The trust took action in response to reported incidents and feedback was provided to staff to ensure learning from previous incidents was achieved. When something went wrong there was an investigation, carried out by appropriate staff. Patients were included in discussions and feedback about their care.

Systems and processes were in place to promote the control of infection and ensure equipment in use was safe by servicing, maintenance and keeping it clean. Safeguarding women and babies was given high priority by the staff who were proactive in identifying and liaising with a multidisciplinary team to ensure the involvement of appropriate staff.

Systems were in place to review staffing levels to ensure they were safe. The staffing levels and skill mix on both the consultant-led obstetric unit and the gynaecology ward was discussed at handover and arrangements were made, if necessary, to risk assess and manage the staffing of each area. The consultant presence on the consultant-led obstetric unit had been measured against guidelines in Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007). As the level of cover was lower than that recommended, this had been placed on the risk register and a business plan was

Summary of findings

being developed to obtain increased consultant cover. The safety of women was promoted by consultants attending the unit over the weekends in their on-call rota time.

The care and treatment provided to patients was effective in that patients experienced care, treatment and support that provided good outcomes for them.

The integrated model which the trust maternity service runs (Nurture programme) allowed flexible use of staff to maintain 1:1 care in labour. This had kept women's denied choice of place of birth to a minimum. However, the access and flow of women through the maternity unit had affected where staff were required to work and on rare occasions affected the choices women could make on where they delivered their baby. Because of pressures on medical beds, some medical patients were transferred to the gynaecology ward, which had increased the numbers of cancelled gynaecology operations. An action plan was in place to reduce the waiting time for women whose operation had previously been cancelled.

Patients' care and treatment was provided in line with current evidenced-based guidance, national recommendations and legislation. Care and treatment was updated following changes in best practice guidance and legislation. The trust monitored the care and treatment provided to women; the data showed women received an effective service when compared with women in other parts of England.

Patients received an outstanding caring service because staff involved and treated patients with compassion, kindness, dignity and respect. Relationships between the staff and patients were strong, caring and trusting. Patients and their representatives were encouraged to make choices and were involved in their care and treatment. Staff took patients personal, cultural, social and religious needs into account when providing care and treatment.

Patients were actively encouraged to complete quality monitoring surveys and participated in the national NHS Friends and Family Test quality surveys, from which positive responses had been received.

Summary of findings

Patients received a responsive service because the service provided was organised to meet the needs of women in their local areas. For example, antenatal and postnatal clinics and the midwife-led birthing units. Additional gynaecology clinics and appropriately trained staff had been put in place to meet the increased demand of newly referred patients. Women were informed on how to make a complaint and complaints were acted on and monitored effectively by the women's and children governance and quality committee. The service was well led because the leadership, management and governance of the organisation assured the delivery of high-quality person-centred care and promoted an open and fair culture. Staff were positive about the management of their services and the accessibility to their line and senior managers. Innovative practice was encouraged and in evidence within the trust, including the development of an application to be used on smart phones and tablets enabling women to access information to make choices and decisions regarding their birth. Student midwives had support from experienced community midwives to run a postnatal clinic to increase their knowledge and competencies.

Services for children and young people

Good



Children, young people and their families were very positive about the care and support they received. They told us they were kept informed and involved in making decisions and were partners in their care. There was a strong family- and child-focused culture in the service. The paediatric unit was purpose built and provided a bright and 'child-friendly' environment. Original plans included a ward for teenagers and adolescents, but this ward was now used by another service. We found facilities for teenagers on the unit were limited and they were sometimes cared for in bays with children and babies of all ages. There was no designated high dependency area; due to a shortage of cubicles the original space allocated for the high dependency unit was converted to accommodate small babies, and so these patients were spread across the medical ward.

Summary of findings

There was no single point of access for emergency care; the children's emergency department and children's assessment unit (CAU) had different roles in the pathway, which were not always clear or efficient. But children and young people known to the service, with long-term conditions, had direct access to the CAU.

The service had identified these issues as part of their strategic ambitions, but detailed plans were still in development.

There were effective procedures to support safe care for children and young people and to keep them safe from avoidable harm. Staff were aware of how to report incidents and this information was monitored and reviewed, and learning was shared with the staff. There was sufficient medical staffing, team working, protocols, robust records and communication, to support safe care and manage risk. Nursing staffing levels and skill mix were planned using national guidance, with contingencies for to staff work flexibly across the service as required. But a formal acuity tool was not used for assessing staffing levels to meet patient needs.

Care and treatment was provided in line with best practice guidance and outcomes were positive. The outcomes for babies on the neonatal unit were good when benchmarked against other services. Staff were well trained and supported in their role and were provided with development opportunities. There was good multidisciplinary team working and a seven-day service was established.

The service had strong and visible leadership. There was a culture of continual learning and improvement, which was supported by strong leadership and multidisciplinary team working. Risks and quality were monitored at all levels, with action taken and changes made when needed. There was good communication and engagement with staff and innovation was encouraged. Children and young people and their parents were encouraged to provide feedback and ideas for improving the service.

**End of life
care**

Requires improvement



Nurse staffing levels in some ward areas meant that the personal care needs of patients receiving end of

Summary of findings

life care were not being met. The trust also needed to improve the medical staffing levels, in particular consultant staffing for palliative and end of life care in line with national recommendations. Nursing staff were not doing appropriate safety checks on syringe drivers when these were being used by patients. Pressure relieving air mattress were not available for patients when required and therefore increased the risk of patients developing pressure ulcers.

The trust had one standard form for do not attempt cardio pulmonary resuscitation (DNACPR) decision which was introduced in 2014. However, some ward areas still retained and used old forms and these did not include any guidance for completion. The trust DNACPR audits demonstrated gaps in completion but there had been improvements. During our inspection, however, we found some forms were not completed according to national guidelines.

Staff reported incidents on the trust-wide electronic reporting system. They also received feedback from concerns and incidents reported. Staff had a good understanding of safeguarding. Medicines were appropriately managed and staff followed infection control procedures.

Following the withdrawal of the Liverpool Care Pathway in July 2014, the trust was piloting new care plans for end of life care on four wards. These were completed to an acceptable standard. However, where these care plans were not used, the documentation, of care was not appropriate to properly assess and make decisions about patient care. We found some staff were not aware of end of life care principles and there was a reluctance to make end of life care decisions.

The AMBER care bundle was an approach used in hospital when doctors were uncertain whether a patient may recover. Generally, it was initiated when patients had a few months to live. The roll out of the AMBER care bundle had been kept to a limited number of wards to ensure its effectiveness due to the sensitivity of the removal of the Liverpool Care Pathway, and to avoid confusion during the

Summary of findings

introduction of the Wessex wide Achieving Priorities of Care (APoC). Most patients received appropriate pain relief and had appropriate nutrition and hydration.

The trust only partially participated in the National Care of the Dying Audit – Hospitals (NCDAH) 2013/14 and was not able to compare its performance with other trusts. For the organisational key performance indicators the trust scored better or the same for five out of seven indicators. Local audits demonstrated some progress with clinical and organisational performance indicators.

Both the hospital palliative care team staff and end of life care team were supported to develop their knowledge and competencies. The hospital had strong links with the local hospice. Whilst the organisation was not part of the trust, it worked closely with the palliative care physician. The end of life care support team provided a 7 day service during specific hours. The hospital had access to 24 hour palliative medicine consultant advice 365 days a year

During our inspection we observed staff were compassionate and caring and treated patients with dignity and respect. Families told us they were well informed about the condition of their relatives. Services were being planned to meet and delivered in a way that met the needs of the local population. For example, the trust had introduced a seven day service on the ward by the end of life care team and was planning to merge the palliative care and end of life care teams to provide a more seamless service. Information was being used to improve awareness of the service across the trust so that patients were appropriately referred to the teams. Most patients were being seen within 24 hours of referral to the teams. Many patients requiring end of life care were treated in side rooms. There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than national average.

The leadership team had developed a draft revised strategy for end of life care that took into account national guidance and reports on improving end of life care. The strategy outlined initiatives to improve and monitor the quality of care, care coordination

Summary of findings

and the culture of care in the trust and working with community teams. The leadership was knowledgeable about quality issues and priorities. Senior staff members took appropriate action to address these issues. There was a culture of responsibility between the end of life care team and the palliative care team. However, risks needed to be better identified, assessed and managed. The trust had a Listening into Action initiative enabled staff to provide solutions to common challenges for end of life care in the trust. Patients and their relatives were to be consulted on the strategy and the relatives of bereaved patients had been surveyed to improve the service. There were innovations in practice, which included integrated care and trained volunteers to support patients.

Outpatients and diagnostic imaging

Good



All outpatient and diagnostic imaging departments demonstrated good knowledge of reporting incidents and of learning from incidents. These were often shared with other outpatient specialities, but real learning only occurred within the speciality reporting the incident. All mandatory training, including safeguarding and infection control, was completed by all staff. Compliance for mandatory training was well monitored by senior staff members.

National Institute for Health and Care Excellence guidelines were followed in many departments and some excellent examples of practice was demonstrated. Staff were encouraged to develop professionally and regularly update their clinical skills. Rheumatology, dialysis and respiratory outpatient departments demonstrated outstanding practice and accomplishments.

Patients were positive about their experiences of care, including care that had been extended to relatives.

In ENT, patients were given access to a private room when they were being given difficult news or were distressed. A symbol on the door indicated to other staff not to enter the room. The privacy and dignity of patients was mostly adhered to. There were, however, some concerns about the building design affecting the privacy of patients in the dialysis unit

Summary of findings

on the Isle of Wight and in the ophthalmology department at Queen Alexandra Hospital. There were risks relating to infection control at the dialysis unit on the Isle of Wight.

Staff across outpatients and diagnostic imaging demonstrated a good understanding of how to make reasonable adjustments for patients living with dementia or those with a learning disability. The waiting times for diagnostic imaging have historically been significantly higher than the national average up until July 2014. The Trust had met the waiting times for diagnostic imaging from September 2014, having extended the working day in the service to achieve this. In rheumatology, a rapid access clinic operated. Patients may receive an appointment that suits their existing commitments; often same-day appointments are available. It also provided innovative patient education and support conferences that are well attended by patients and have been nominated for awards.

The referral-to-treatment targets for most outpatient specialities were being met, although colorectal, back pain and the gastroenterology clinics had longer waits. The trust taking action to addressing this issue. Cancer urgent referral times for patients to be seen within two weeks were being met.

Ophthalmology had a high number of patients awaiting follow-up who were significantly delayed in receiving their follow-up appointment and were on the outpatients waiting list. This had been on the service risk register since 2009, as a result of a serious incident requiring investigation that occurred as a result of this backlog, it was escalated to the trust risk register In April 2013. This number had been reduced, but the number of patients waiting was still significant. The learning from this had improved how risks were escalated. Risks were being managed and waiting lists and service quality was monitored.

Renal outpatient letters were taking 35 days to be typed and sent to the patients' GP. This was because the renal department had a separate IT system from the rest of the trust. It had caused

Summary of findings

significant delay in GPs receiving updated information regarding their patients' treatment. An outpatients administration review was underway to improve services within the department.

Queen Alexandra Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Queen Alexandra Hospital

Portsmouth Hospital NHS Trust provides a full range of elective and emergency medical and surgical services to a local community of approximately 675,000 people who live in Portsmouth city centre and the surrounding areas of South East Hampshire. It provides some tertiary services to a wider catchment of approximately two million people. The trust also provides specialist renal and transplantation services and is host to the largest of five Ministry of Defence Hospital Units in England.

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances and over 429,000 outpatient attendances each year. There are 6,000 staff employed by the trust and approximately a further 1,000 are employed by a provider in portering, cleaning, maintenance and catering services under PFI arrangements. The trust has not yet applied for foundation status.

The trust also provides outpatient services in community hospitals at Gosport War Memorial Hospital, Petersfield Community Hospital and St. Mary's Hospital. Gosport War Memorial Hospital has a minor injuries unit, inpatient rehabilitation on Ark Royal Ward (16 beds) and the Blake Maternity Unit (six beds). Petersfield Community Hospital has inpatient rehabilitation on Cedar Ward (15 beds) and the Grange Maternity Unit (four beds). There are eight satellite renal dialysis services, with six across Hampshire, one in Salisbury (Wiltshire) and one in Bognor Regis (West Sussex).

Services provided at Queen Alexandra Hospital include accident and emergency, medical care, surgery, critical care, maternity and gynaecological services, children and young people's services, end of life care, and outpatient and diagnostic services. These eight core services are always inspected by the Care Quality Commission (CQC) as part of its new approach to the comprehensive inspection of hospitals. The services provided in community hospitals are integrated into the trust clinical and management structures; we have incorporated these within the core service areas.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector for Hospitals, Care Quality Commission.

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission.

Detailed findings

The team of 56 included CQC managers, inspectors and analysts, and a variety of specialists including: consultant in emergency medicine; consultant gynaecologist and obstetrician; consultant surgeon; consultant anaesthetist; consultant physicians; consultant geriatricians; consultant radiologist; consultant oncologist; consultant paediatrician; junior doctor; emergency department

matron; midwife; gynaecology nurse; surgical nurses; theatre nurse; medical nurses; paediatric nurses, neonatal nurse specialist, optometrist; palliative care specialist nurse; critical care nurses; outpatient manager, board-level clinicians; governance lead; safeguarding leads; a student nurse; and experts by experience.

How we carried out this inspection

We carried out an announced inspection visit from 10 to 13 February 2015. We completed the inspection through unannounced and out-of-hours inspections to services on 25 and 26 February and 2 March 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; Monitor; Health Education England; General Medical Council; Nursing and Midwifery Council; 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 Portsmouth on 10 February when people shared their views and experiences of the Portsmouth Hospitals NHS Trust.

We conducted focus groups and spoke with a range of staff in the hospital, including nurses, matrons, junior doctors, consultants, administrative and clerical staff, porters, maintenance, catering, domestic, 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 outpatient 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 the Portsmouth Hospital NHS Trust.

Facts and data about Queen Alexandra Hospital

Queen Alexandra Hospital: Key facts and figures

Queen Alexandra Hospital is the acute hospital provided by Portsmouth Hospital NHS Trust.

1. Context:

- The hospital has around 1,255 beds.
- The local population is around 550,000.
- The number of staff is around 6,000.
- The board has 0% Black and ethnic minority members representation of executive directors and 0% Black and ethnic minority members representation of non-executive directors; it has 33.3% female representation of executive directors and 20% female representation of non-executive directors.

- Deprivation in the City of Portsmouth is higher than average (76 out of 362 local authorities). The surrounding areas of Gosport, Fareham and East Hampshire are less deprived.
- Life expectancy for both men and women is worse than the England average.
- The trusts income for 2013/14 was £469,147,000; the costs were £468,317,000.
- The trust surplus was £830,000 (2013/14).

2. Activity:

- Inpatient admissions: 96,146 (2013/14).
- Outpatient attendances: 463,515 (11/2013 to 10/2014).
- A&E attendances: 137,864 (11/2013 to 10/2014).

Detailed findings

- Births: 5,966 (July 2013 to June 2014) 98.5% single births and 1.5% multiple births.
- Deaths: 805 (April 2013 to March 2014).

3. Bed occupancy:

- General and acute: 92.2% (April 2014 to June 2014). 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.
- Maternity was at 71% bed occupancy (April 2014 to June 2014) and consistently higher than the England average of 57.9%.
- Adult critical care was at 82.4% bed occupancy – below the England average of 87.6% in January 2015.
- Level three neonatal intensive care unit.

4. Intelligent Monitoring:

Priority banding for inspection*

Oct 13 - 4 (4.3%)

Mar 14 - 6 (0.5%)

Jul 14 - 6 (2.1%)

Dec 14 - 6 (3.2%)

*For each acute trust we have published an intelligence monitoring report. We have also placed each trust into a priority band from one (highest perceived concern) to six (lowest perceived concern). While the bands will help us to decide which trusts we may inspect first, they don't represent a judgement or a ranking of care quality.

Individual risks/elevated risks:

- Elevated risk: Composite indicator, A&E waiting times more than four hours (July 2014 to September 2014).
- Elevated risk: Diagnostic waiting times: Patients waiting over six weeks for a diagnostic test (July 2014).
- Risk: Sentinel Stroke National Audit Programme Domain 2: Overall team-centred rating score for key stroke unit indicator (April 2014 to June 2014).
- Risk: TDA Escalation score (June 2014).

5. Safe:

- 'Never events' in past year: 3 (2013/14).
- Serious incidents: 116 (2013/14) – 63% were pressure ulcers.

- National Reporting and Learning System April 2013 to May 2014; no evidence of risk.

Acute

Death - 7 (0.1%)

Severe harm - 101 (1.3%)

Moderate harm - 138 (1.8%)

Low harm - 2,405 (30.5%)

No harm - 5,212 (66.3%)

Total **7,863**

Infection control (March 2013 to September 2014)

- 53 cases of Clostridium difficile – no evidence of risk.
- Three cases of MRSA – incidence – no evidence of risk.

Waiting times – Safe Domain

- A&E – time to initial assessment: above (from January 2014) the England average and 15 minute standard (January 2013 to October 2014).
- A&E – time to treatment: similar to the England average, and standard time of 60 minutes (January 2013 to October 2014).

6. Effective:

(December 2014)

- Hospital Standardised Mortality Ratio: no evidence of risk (Intelligent Monitoring).
- Summary Hospital-level Mortality Indicator: no evidence of risk (Intelligent Monitoring).

7. Caring:

- CQC Inpatient Survey (10 areas): similar to other trusts.
- Friends and Family Test inpatient: 96% above the England average 94% (January 2015).
- Friends and Family Test A&E: 95% above the England average 88% (January 2015).
- Cancer Patient Experience Survey (34 questions): similar to other trusts for 30 questions; lowest scoring 20% of trusts for two questions and highest scoring 20% for two questions.

8. Responsive:

- A&E four-hour standard – not met; below the England average and 95% target (April 2013 to December 2014).

Detailed findings

- 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 (December 2013 to September 2014).
- 18-week referral-to-treatment – surgery (admitted adjusted) – similar to 90% NHS operating standard (April 2013 to June 2014).
- 18-week referral-to-treatment (non-admitted and incomplete pathways – outpatient) – above 95% NHS operating standard (April 2013 to June 2014).
- Cancelled operations and not treated within 28 days – above the England average in June 2014.
- Cancer waiting times: Better than or similar to England average for urgent two weeks (seen by specialist), 31 days (diagnosis to treatment) and 62 days (urgent referral to treatment).
- Diagnostic waiting times – Although flagged as an Elevated Risk by Intelligent Monitoring, waiting times had dropped below the England average by October 2014.
- NHS Staff survey 2013 (30 questions): Better than expected (in top 20% of trusts) for two questions; worse than expected for seven questions; similar to expected for 21 questions.
- Use of bank and agency staff – below the England average.
- Sickness rate – below the England average.
- General Medical Council National Training Scheme Survey (2013): The trust was within expectations for all areas of the National Training Scheme Survey.

10. CQC Inspection History:

- Eight inspections had taken place at the trust since August 2011. All inspections have been at Queen Alexandra Hospital.
- The trust was non-compliant with Outcome 9, Medicines management and Outcome 4, Care and welfare of people who use services in October 2011, and later was non-compliant for Outcome 21, Records in March 2012. All three outcomes have been re-inspected and the trust found compliant.

9. Well-led:

Our ratings for this hospital

Our ratings for this hospital are:







Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Critical care	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Maternity and gynaecology	Good	Good	Outstanding	Good	Good	Good
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	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Queen Alexandra Hospital, Portsmouth is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment such as lacerations and suspected broken bones. The ED is a recognised trauma unit, although major trauma cases go directly to Southampton. The department sees approximately 132,000 patients each year.

The department has a four-bay resuscitation area; one bay is designated for children. There is major treatment area, a major treatment 'queueing' area and a minor treatment area for less seriously ill or injured patients. The department has a separate children's treatment area with its own waiting room and resuscitation room. There is a nine-bedded observation ward.

There is a small urgent care centre where patients can be treated by a GP if their condition is not an accident or emergency.

The ED is also responsible for the minor injuries unit at Gosport War Memorial Hospital, which sees approximately 5,000 patients a year.

We visited over three weekdays and returned unannounced during a weekday evening. We observed care and treatment and looked at treatment records. During our inspection, we spoke with approximately 40 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance

crews. We talked with 21 patients and four relatives. We received comments from patients and the public at our listening events, and we reviewed performance information about the department.

Urgent and emergency services

Summary of findings

We have issued two warning notices because safety was inadequate in the emergency department (ED). Severe overcrowding meant that ambulance patients had to wait on trolleys in a corridor before being assessed and some patients with serious conditions had waited over an hour to be assessed. Patients were not appropriately monitored and observed while waiting in the corridor and there was a high risk of their condition deteriorating during this time.

The environment in the department did not enhance patient safety. The department had changed to accommodate more patients. However, staff had to negotiate crowded public areas in order to gain access to the resuscitation room and staffing levels had not changed to take account of the increase in the number of patients. There was an over-reliance on agency nurses on late shifts and a lack of experienced doctors at night. Consultant staff were extending their working hours overnight and into early mornings to ensure safety, but this was not sustainable practice.

Patients were in areas, including some temporary areas, where there was no access to essential equipment or call bells, and there was no safe area to support patients who may have a mental health condition. Once assessed, the early warning score was used to monitor patients whose condition might deteriorate, but this was not used to determine clinical need for admission to an inpatient bed. Patients were not being seen by a specialist doctor in a timely way if they had been in the department overnight.

Children had appropriate separate facilities within the department. Safeguarding was understood and protocols were followed. Staff were aware of safety issues and demonstrated that it was at the forefront of their thinking. Incidents were reported promptly and investigated appropriately. Learning from incidents was shared with staff and used to improve the service. Medicines and records were appropriately managed and infection control procedures were followed. The minor injuries unit at Gosport War Memorial Hospital followed appropriate practice standards.

Policies and procedures were developed in conjunction with national guidance and best practice evidence and the department undertook national and local audits. Pain relief was offered appropriately in most cases, and its effectiveness was assessed and acted on. Patients were offered food and drink.

Staff were competent and had undertaken appropriate specialist training. Multidisciplinary working was in evidence so that the needs of each patient were prioritised. Staff had a good understanding of consent and the Mental Capacity Act 2005.

The staff provided compassionate care and ensured that patients were treated with dignity and respect. We saw outstanding care being given to relatives in the resuscitation room. There were positive comments from patients about the care received and they and their relatives were kept informed of ongoing plans and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options. Play leaders in the children's treatment area provided distraction from potentially upsetting treatment such as injections and nebulisers.

There were large numbers of people arriving by ambulance and the flow of patients in the ED was often blocked by internal capacity issues in the hospital. The trust had not achieved the national emergency access target to admit, transfer or discharge 95% of patients within four hours of arrival since November 2013. It was not meeting the national target to receive and assess ambulance patients within 15 minutes of arrival. There was no adequate escalation plan to manage overcrowding in the ED and address these issues. There was no single point of access for children who need emergency care, as recommended by national guidelines.

Staff responded well to patients' individual needs. There was a clear understanding of the requirements of people living with dementia or a learning disability. Relatives were encouraged to stay with them while in the department. Complaints were handled appropriately and the learning was used to improve services.

Urgent and emergency services

The department did not have a written strategy and appropriate actions had not been taken to reduce the risks associated with delays to patient treatment. Governance arrangements were monitoring risks and quality, and there was appropriate escalation of concerns. However, medical and nursing staff expressed a sense of isolation from the rest of the hospital and were unable to resolve problems with flow without hospital support. The department did not consider it had adequate levels of clinical leadership.

Staff told us that the ED had an open and honest culture and excellent teamwork. Medical leadership was constantly visible in the clinical environment. The leadership team demonstrated the skills, knowledge and experience needed for their roles.

Are urgent and emergency services safe?

Inadequate



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

We rated safe as inadequate.

We served two warning notices under safety for care and welfare of patients and assessing and monitoring the quality of service provision.

Severe overcrowding meant that ambulance patients had to wait on trolleys in a corridor before being assessed by a member of emergency department (ED) staff. The initial assessment of patients took longer than the national standard of 15 minutes and some patients with serious conditions had waited over an hour to be assessed. Patients were not appropriately monitored and observed while waiting in the corridor and there was a high risk of their condition deteriorating during this time.

The environment in the department did not enhance patient safety. The ED had been extended and the majors treatment area and the children's treatment area were now a considerable distance from the resuscitation room. Staff had to negotiate crowded public areas in order to gain access to the resuscitation room. There was a newer majors queueing area and medical and nurse staffing levels had not been increased to take account of the increase in the number of patients in the department. There was an over-reliance on agency nurses on late shifts and a lack of experienced doctors at night. Consultant staff were extending their working hours overnight and into early mornings to ensure safety, but this was not sustainable practice.

Patients were in areas, some temporary, where there was no access to essential equipment or call bells, and there was no safe area to support patients who may have a mental health condition. Once assessed, the early warning score was used to monitor patients whose condition might deteriorate, but this was not used to determine clinical need for admission to an inpatient bed. Patients were not being seen by a specialist doctor in a timely way if they had been in the department overnight.

Urgent and emergency services

Children had appropriate separate facilities within the department. Safeguarding was understood and protocols were followed. Staff were aware of safety issues and demonstrated that it was at the forefront of their thinking. Incidents were reported promptly and investigated appropriately. Learning from incidents was shared with staff and used to improve the service. Medicines and records were appropriately managed and infection control procedures were followed. The minor injuries unit at Gosport War Memorial Hospital followed appropriate practice standards.

Incidents

- There were three serious incidents in the ED in 2013/14. The department had investigated serious incidents in a timely and thorough way. Clinical measures were identified to help prevent a repeat of similar incidents. Learning points from incidents were clearly described in governance meeting minutes. There had been two additional serious incidents that had happened in the previous fortnight before the inspection. These were being investigated appropriately.
- We looked at the ED incident reports from 1 July 2014 to 30 October 2014. These had been logged on the hospital incident reporting system. The incidents were clearly described and appropriate remedial action taken when necessary. There were nine reports of excessive overcrowding in the ED that had directly resulted in delays in assessment and treatment. These were ambulance patients waiting on trolleys in corridors or in ambulances. Measures had not been identified to reduce the reoccurrence of repeated incidence based on overcrowding.
- Staff told us the trust was investigating ways to reduce the number of patients waiting in the department. However, it was thought to be a complex problem and progress in solving this had been slow.
- Several staff told us that they received monthly emails that gave them up-to-date information on the department's safety record as well as governance and quality topics.
- Learning from incidents and 'near misses' was clearly displayed on a noticeboard in the staff room.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected

patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days.

Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS

- Information about the duty of candour was displayed on the noticeboard in the ED staff room. Senior staff demonstrated detailed knowledge of the practical application of this new responsibility.
- All staff who we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour.

Cleanliness, infection control and hygiene

- The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day.
- Hand washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. This helped to prevent the spread of infection. However, during a particularly busy evening we observed that nursing staff did not always clean their hands between caring for different patients.
- Sluices were clean and well organised, and clinical waste was handled and disposed of safely.
- Audits of infection prevention and control practices were carried out, reviewed and actions plans implemented if necessary. Monthly audits of hand washing showed that compliance with good practice was between 97% and 100%. This exceeded trust targets.
- We observed staff treating a patient in isolation in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.
- Computers in the department had special wipeable keyboards that help to prevent transfer of infectious organisms.
- There were good standards of cleanliness at the minor injuries unit at Gosport War Memorial Hospital and reliable systems in place to protect people from infection.

Urgent and emergency services

Environment and equipment

- The physical environment did not enhance patient safety. The layout of the ED had evolved over time and had been altered to try and accommodate increasing numbers of patients.
- There was a relatively new and spacious resuscitation room. However the major treatment area was older and divided in two. The major treatment area had originally been designed as an acute medical unit. It had been changed to a major treatment area in order to accommodate increasing numbers of ED patients. A smaller area was introduced that had room for 12 patient trolleys and was known as the major treatment 'queueing' area. The major treatment area had room for 18 patients and was a considerable distance from the major treatment 'queueing' area and from the ambulance entrance.
- The major treatment queueing area was used as a thoroughfare for staff and visitors between the ED entrances and the major treatment area. As such, it was noisy and congested. Privacy for patients was limited. There were no walls between patient bays, only curtains. This meant that confidential conversations were easily overheard. There were no worktops in the bays, which meant there was nowhere to put essential items such as vomit bowls, hand cleaning gel or gloves.
- The distance between the resuscitation room and the major treatment area was approximately 50 metres. This could result in delays in responding to resuscitation emergencies when senior staff were elsewhere in the department.
- There was an assessment room with space for two trolleys close to the ambulance entrance. This was known as the ambulance streaming area. The purpose of this area was to provide facilities for the rapid assessment of ambulance patients by a senior nurse. Once the assessment was completed, patients would be taken to an appropriate treatment area.
- The ambulance streaming area was designed for two patients. However, throughout our inspection it was usual for each bay to be divided by a screen so that a total of four patients could be assessed and, if necessary, stabilised. This was because patients could not be transferred to treatment areas since they were often full.
- Dividing the bays meant that only two patients had access to emergency suction equipment or a call bell.

We observed a patient being nursed in one of these temporary cubicles who because of significant injuries could not move. There was no nurse available to monitor the patient's condition and the patient could not summon help if it was needed. This meant that patient safety was compromised.

- The department was full during most of our inspection. This meant that, although four patients were being assessed in the ambulance streaming area, there was no room for new ambulance patient arrivals. As a consequence there were often as many as seven patients lying on trolleys in the corridor leading from the ambulance entrance.
- We saw patients with conditions such as a suspected broken hip, chest pain, shortness of breath and an infectious disease waiting in the corridor. It sometimes took more than an hour for patients to be clinically assessed, which meant that their condition was at risk of deteriorating. Patients in the corridor were also queueing around a corner and this meant they were not in the line of sight for observation by nursing (or paramedic) staff. We observed one patient with a head injury get up, unobserved, to leave the department and an inspector had to prevent him from falling and colliding with another elderly patient on a trolley.
- There were times when there was no more room in the corridor. In response to this, the ambulance service had provided temporary accommodation for patients. This was a former Ambulance Control incident vehicle, which been converted to hold up to three patients awaiting admission to the ED. We looked inside the vehicle and found it to be cramped and with no curtains or screens between patient trolleys. There was an unpleasant smell of disinfectant. The lack of dignity and privacy associated with this vehicle was unacceptable.
- When more than two ambulance crews were waiting to hand over patients, the corridor became very crowded. We saw a number of collisions between patient trolleys as a result. This caused additional stress and discomfort to the patients on the trolleys.
- The ED had a separate children's treatment area that was spacious and well designed. People could only access this area through an electronic door system, which was monitored by staff at all times. This increased the safety of the children being treated.

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- Children and their parents had a separate waiting area that contained a selection of toys suitable for children of different ages. There was an additional waiting room for teenagers.
- The children's treatment area was at the far end of the department next to the ED reception and waiting room. If a child needed to be resuscitated, staff had to run through the waiting room in order to access the resuscitation room. We were told that this could be difficult if there were a lot of people standing in front of the reception desk.
- There was a large waiting room for patients who brought themselves to the ED. It had sufficient numbers of comfortable seats, a supply of drinks and snacks from a vending machine and a television showing news programmes.
- In an effort to reduce the number of people standing in front of reception, patients were asked to take a numbered ticket from a machine and then sit down in the waiting room. They were then called to the reception desk in time order.
- The ticket machine was not easy to see and we observed a number of patients and visitors walking straight to the desk without taking a ticket. Sometimes they were dealt with immediately and on other occasions they were asked to go back and take a ticket. This caused confusion and anxiety for many people.
- There was a small x-ray department within the ED. This was well equipped and accessible from all areas of the department. There was a dedicated entrance from the children's treatment area. This ensured that children's exposure to adult patients was kept to a minimum.
- There were no designated facilities for people suffering from mental health problems. We were told that, for safety reasons, people who were exhibiting disruptive behaviour could be isolated in a side room next to the ambulance entrance. However, this room was also used as an overflow resuscitation bay and was equipped as such. The medical equipment and sharp implements within the room meant that it was not a safe environment for people with mental health problems.
- There was a good range of resuscitation, monitoring and decontamination equipment. This was clean, well maintained, regularly checked and ready for use.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs and fridge temperatures were regularly checked by staff working in the department.
- Daily checking of the temperature of drug fridges in the minor injuries unit in Gosport War Memorial Hospital was not always carried out. This meant that drugs may not have been stored at the correct temperature.
- Unused drugs were disposed of in accordance with hospital policy.
- We observed staff administer intravenous fluids safely and correctly. They methodically completed details on the medication chart.

Records

- The department had a new computer system that showed how long people had been waiting for and what investigations they had received.
- The system produced a patient record in paper format and all healthcare professionals documented care and treatment using the same document.
- The records we looked at were clear, complete and easy to follow. There was space to record appropriate assessment, including assessment of risks, investigations, observations, advice and treatment and a discharge plan.

Safeguarding

- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. The "At risk" register was checked for all children up to and including the age of 17 years.
- All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare.
- All staff (including administrative staff) were expected to do level 2 child protection training and senior clinical staff were expected to undertake level 3 training.
- At the time of our inspection 95% of staff had completed annual training in adult safeguarding and 93% had completed children's safeguarding training.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control and manual

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handling. Training records up to January 2014 showed good uptake of this annual training. Rates of attendance varied from 77% for fire training to 91% for manual handling

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.
- Other patients arriving by ambulance were meant to be rapidly assessed by a senior nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. This is often known as triage. However, throughout our inspection there were between four and seven ambulance patients waiting in a corridor to be assessed or triaged.
- We observed patients with potentially serious conditions waiting in the corridor for over an hour before their initial assessment took place. This meant that their treatment was delayed and that their condition was at significant risk of deteriorating.
- Staff were aware of the risks and were frustrated that their efforts to improve the situation had had limited success.
- One member of staff gave us an example of an incident which had taken place the previous week. We looked at the relevant medical records and saw that the patient had been brought by ambulance because of breathing difficulties. The patient had previously had a heart attack and needed oxygen to help the breathing difficulties. Despite this the ambulance crew had to wait for 25 minutes to handover to the assessment nurse. Nursing staff started their assessment but shortly afterwards the patient's condition deteriorated and they had to be rapidly transferred to the resuscitation room.
- In order to prevent large numbers of ambulances waiting outside the ED, South Central Ambulance Service NHS Foundation Trust had deployed two members of staff to assist the trust to monitor the condition of patients in the corridor. The trust staff told us they were there to prioritise the assessment of patients who were causing concern. However, equipment and space for the ambulance staff to clinically monitor patients in the corridor was limited. Throughout our inspection we observed that patients were assessed according to the time that they arrived in the department, not according to clinical need.
- The ambulance staff did not have a line of sight for all patients in the corridor. At one point we observed a patient sliding from the end of the trolley. We brought this to the attention of the ambulance staff so that the patient could be placed in a safe position on the trolley.
- A national target has been set that states ambulance patients should be handed over to the care of ED staff within 15 minutes. The hospital was failing to meet that target. Figures sent to NHS England showed that the average waiting time to initial assessment was 25 minutes.
- When we returned for our unannounced inspection we were told that the ED had been allocated an additional healthcare assistant whose role was to assess the patients in the corridor. If there were any concerns they would be discussed with the nurse in the streaming area. The Triage Position Statement, April 2011 issued by The College of Emergency Medicine, Clinical Effectiveness Committee; Emergency Nurse Consultant Association; Faculty of Emergency Nursing and Royal College of Nursing, Emergency Care Association states that this initial assessment must be undertaken by a trained clinician and not a healthcare assistant.
- Two patients told us that they did not feel safe in the corridor. One had been waiting for approximately one hour and another over two hours. The second patient told us that they only felt safe when their family arrived.
- Patients who walked into the department, or who were brought by friends or family, were directed to a receptionist. Once initial details had been recorded the patient was asked to sit in the waiting room. These patients were assessed by a nurse in time order unless the receptionist thought that a patient needed to be seen urgently. Walk-in patients rarely had to wait more than 10 minutes during our inspection.
- We observed the initial assessment of two patients (with their consent) and found it to be thorough and effective. The nurse had undergone specific training before carrying out the role and was able to request x-rays when indicated.
- The assessment room was situated next to the waiting room and nursing staff were able to observe activity

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there. We witnessed rapid and effective intervention by a nurse when a patient felt faint while waiting to be seen. This helped to ensure the safety of people when they first arrived.

- Early warning scores (EWS) were used throughout the department. This is a quick and systematic way of identifying patients who are at risk of deteriorating. Once a certain score is reached a clear escalation of treatment is commenced. The scores were not used when requesting a bed on a ward when patients needed to be admitted. This meant that the manager trying to find a bed did not have an objective understanding of the seriousness of the patient's condition.

Nursing staffing

- Nurse staffing levels were based on historical establishments which had been reviewed over time to take account of changing demand. A specific staffing acuity tool was not used. The ED nursing staff told us the nursing establishment did not take account of the ambulance queueing area as this was new arrangement. Therefore the department depended on trust staff and temporary staff to backfill trust staff to look after the additional patients.
- Throughout our inspection the major treatment queueing area was staffed by two nurses. There were twelve patients in the area and NICE guidelines state that there should be a minimum of three nurses. This meant that patients were at risk of poor care because of insufficient nurses.
- The head of nursing for the ED told us that she tried to achieve the staffing levels recently recommended by the National Institute for health and Care Excellence (NICE) but that there were not always appropriately trained temporary nurses available. During our inspection we witnessed the nurse in charge trying to arrange for five nurses from an agency to work with the night staff. This represented a third of the nurses on duty.
- Although agency nurses are fully qualified they do not always have specialist experience needed in ED and have often not worked in the department before. This means that some patients will not be looked after by nurses with the experience required. Senior staff told us that agency nurses often did not have the clinical assessment skills required in an emergency setting and did not have up-to-date resuscitation skills.

- The NICE recommendation to have a Band 7 sister in charge of the department on each shift was achieved frequently. There were three consultant nurses and a supervisory band 7 role in the ED and acute medical unit.
- We spoke to five members of nursing staff at length and they said that, on the whole, they enjoyed working in the department and were well supported by senior staff. They felt frustrated by the long delays in admitting patients to a ward but felt that this was due to a shortage of beds rather than any lack of effort by their direct managers.
- This was reflected in the low sickness rate amongst the ED nursing team which varied between 1 and 3%. Nursing turnover rates were also low at 4 %.
- Staffing levels at the minor injuries unit at Gosport War Memorial Hospital were good. There were always two emergency nurse practitioners on duty. A triage nurse arrived later in the day when more patients attended.
- There was always at least one nurse with specialist children's training on duty day and night, in order that sick children were well cared for.

Medical staffing

- The department employed 13 consultants to treat patients, of which two consultants specialised in the treatment of children. Their rota ensured a consultant presence from 8am until midnight. There was a consultant on-call at night. This was in line with recommendations from the College of Emergency Medicine.
- There were two additional consultants who were children's specialists. They worked in the department from 8am until 10pm, in line with guidance contained in the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings.
- However, because of the increasing workload of the department, consultants often worked until 2am. On the second night of our inspection the consultant worked until 5am. The staff doubted that these working practices could be sustained.
- Each morning, a consultant reviewed every patient who had remained in the department overnight. During our inspection this included up to 14 patients who had been referred to specialist medical teams and were waiting to be admitted to a ward. Specialist doctors had not seen the patients during the night and so the ED consultant

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reviewed them in order to ensure that they were being appropriately treated. This added considerably to the consultant workload and meant that there was less time to treat ED patients.

- Two of the consultants who we spoke with had trained in the department and had chosen to come back when they had finished their training because of the high levels of support and strong sense of teamwork.
- There were only five middle-grade doctors working in the department, which was lower than the national average. This meant that only one middle-grade doctor could work at night. Because of the sprawling layout of the department, this meant that these experienced doctors could not always ensure timely treatment for the sickest patients.
- In response to this, the consultants had arranged to work additional hours in order to ensure patient safety. With their existing work commitments, this solution was not practical or sustainable.
- The department had difficulties recruiting middle-grade doctors and there was concern that one doctor was due to leave soon and may not be replaced.
- Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a safe clinical handover of patients' treatment when shifts changed.

Major incident awareness and training

- The hospital had a major incident plan, which was up-to-date and detailed. The major incident plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts and chemical contamination.
- Staff in the ED were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material.

- ED staff told us there were sufficient security staff in the hospital and that they responded rapidly when called to the department. They were trained and competent in the safe restraint of violent people.
- We observed security staff dealing with a loud and aggressive person in the major treatment area. They were able to rapidly defuse a potentially disruptive situation and persuaded the person to leave. This ensured the safety of the patients and staff in the department at the time.

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.

The department took part in national and local audits. Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK. Audit activity was stronger in medical disciplines because a consultant had been able to take specific responsibility for assessing the effectiveness of treatment delivered in the emergency department (ED). Pain relief was offered appropriately in most cases, and its effectiveness was assessed and acted on. However, there were long delays for patients arriving by ambulance because they sometimes had to wait for over an hour before being taken to a treatment area. Patients were offered food and drink, and these were documented in the patient record.

Staff were competent and had undertaken appropriate specialist training. Multidisciplinary working was in evidence so that the needs of each patient were prioritised. Staff had a good understanding of consent and the Mental Capacity Act 2005.

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Evidence-based care and treatment

- The ED used a combination of NICE and College of Emergency Medicine guidelines to determine the treatment that was provided. Guidance was regularly discussed at governance meetings, disseminated and acted on as appropriate.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE. These included treatment of strokes, asthma and feverish children, safe cannula insertion and multiple trauma. At monthly governance meetings any changes to guidance and the impact that it would have on their practice was discussed.
- In June 2014 the College of Emergency Medicine published revised guidance, 'Crowding in the Emergency Departments'. Compliance with this guidance was mixed. For instance, responsibility for waiting ambulance patients was shared with the ambulance service, but there was no effective hospital escalation plan.
- The department satisfied the requirements of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings.
- The ED participated in a number of national audits, including those carried out on behalf of the College of Emergency Medicine.
- There was also a local audit programme, including topics such as compliance with insulin prescribing, treatment of dislocated shoulders and examination of feverish children. The results of the audits led to refinements and changes in treatment protocols and improvements in the clinical computer system. Updated protocols were shared with all staff in the department.

Pain relief

- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department. However, we witnessed long delays for patients arriving by ambulance because they sometimes had to wait for over an hour before being taken to a treatment area.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.

- Although formal pain scores were not always assessed, four of the five patients who we spoke with reported that they had been offered appropriate pain relief. Records showed that this had been administered promptly and in line with hospital policy.
- The trust scored similar to other trusts in the CQC A&E Survey 2014 for questions on pain relief.

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.
- A new system of regularly offering drinks and snacks to patients had recently been introduced. This was known as a 'comfort round' and was meant to take place hourly.
- We saw staff offering refreshments during the course of our visit, although this was not always recorded in the patient's record.
- The trust scored similar to other trusts in the A&E Survey 2014 for the question on nutrition and hydration.

Patient outcomes

- The College of Emergency Medicine (2013) consultant sign-off audit measures a number of outcomes, including whether a patient has been seen by an ED consultant or senior doctor in emergency medicine before being discharged from the ED when they have presented with non-traumatic chest pain (17 years or older), children under one year of age presenting with a high temperature and patients who present back to the ED within 72 hours of previously being discharged by an ED. Results from the 2013 audit show a number of improvements compared to 2011. In particular, all patients included in the audit who were discharged had been seen by a consultant or senior doctor. This compares with 91% in the rest of the country. This is a significant achievement in a department that did not have a 24-hour consultant presence.
- In the College of Emergency Medicine sepsis audit 2013/14, the trust scored similar to other trusts for initial assessment of patients, rapid administration of oxygen, taking blood cultures and starting antibiotics in the ED. The trust was in the lowest 20% of trusts for initiating intravenous fluids, giving antibiotics within two hours, measuring serum lactate and urine output. Staff told us

Urgent and emergency services

that they thought this was because of lack of facilities for ambulance patients. They had raised staff awareness of the need for rapid treatment and had just undertaken another audit. The results had not yet been received.

- The unplanned re-attendance rate to A&E within seven days was below the England average (2013/14).

Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process.
- Teaching and staff development was a priority in the department. Nursing shift times had been altered to allow for formal teaching sessions two or three times a week.
- Staff told us that there was a structured competency framework so that nurses and their managers knew when they were ready for increased levels of responsibility.
- We spoke with junior doctors, who told us that they received regular supervision from the ED consultants, as well as twice weekly teaching sessions.
- Nurses who we spoke with told us that they had undertaken the Resuscitation Council's Intermediate Life Support course and some had also attended paediatric resuscitation training. However, we could find no records that demonstrated how many nurses had gained these qualifications.
- Nursing staff were supported by an ED education facilitator who was a senior member of staff who also worked clinically. This role coordinates the activities of student nurses within the department and helps to develop competency assessments for qualified staff.

Multidisciplinary working

- There was effective multidisciplinary working within the ED. This included effective working relations with speciality doctors and nurses, social workers, therapists and GPs.
- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- There was a good working relationship with the child safeguarding team and with the community paediatric team.

Seven-day services

- The ED consultants were present seven days a week from 8am to midnight and provided cover 24 hours a day, seven days a week, either directly within the department or on-call.
- The department had access to radiology support 24 hours a day, with rapid access to CT scanning when indicated.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- Discharge letters were clear and comprehensive and were sent to GPs on a daily basis.
- The computer systems provided up-to-date information about patients' condition and progress within the ED. However, information was not available to the triage nurse about patients' previous attendances to the department. This meant that they did not always have sufficient information to prioritise appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Senior staff displayed a commitment to using new mental capacity assessment forms, but they were not able to show us any examples during the inspection.
- When patients lacked the capacity to make decisions for themselves, for example if they were unconscious, we observed staff making decisions that were considered to be in the best interest of the patient. We found that any decisions made had been appropriately recorded within the medical records.

Urgent and emergency services

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.

The emergency department (ED) provided compassionate care and ensured that patients were treated with dignity and respect despite the challenges provided by a crowded department. We saw outstanding care being given to relatives in the resuscitation room.

There were positive comments from patients about the care received, and the attitude of motivated and considerate staff. Patients and their relatives were kept informed of ongoing plans and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options. Play leaders in the children's treatment area provided distraction from potentially upsetting treatment such as injections and nebulisers.

Compassionate care

- During our inspections we saw many examples of patients being treated with compassion, dignity and respect. Staff introduced themselves by name and explained treatment plans in terms that were easily understood.
- People with dementia and learning difficulties were given special consideration. Conversations were held at a pace that suited the individual and simple terms were used to help people understand what was happening.
- Communication with children was well thought out and effective. Play leaders were present in the department until 10pm in order to offer enjoyable distraction from a potentially upsetting experience.
- We spoke with 25 patients and a number of family members. Their experiences had been mixed. Ambulance patients waiting to be seen by a nurse were the least satisfied. One relative said "I had to push hard for Mum to see a doctor, but when the consultant saw

her she was spot on". Patients in the major treatment area were happier with their care and treatment. One said "The staff are very caring. I have been treated very well."

- Another said "We have had a very positive experience."
- One parent we spoke with said, "We have been to the emergency department before. All of the staff are excellent."
- The trust scored above the England average score in the NHS Friends and Family Test for A&E departments. The trust scored similar to other trusts in the 2013 CQC inpatient survey for two A&E questions. These were about privacy when being examined and information about their condition.
- The trust scored similar to other trusts in the A&E Survey 2014. The questions covered access to care, safeguarding, cleanliness, nutrition and hydration, pain relief, compassionate care, patient understanding and involvement, emotional support, access and flow, and meeting patient individual needs.

Understanding and involvement of patients and those close to them

- Some patients were confused about the identity of staff. The staff wore trust ID badges but name badges were additional items that some staff wore. Patients told us it was difficult to know who the staff were.
- One relative had asked for information from a member of administration staff sitting at a desk. He thought he had been talking to a nurse. An elderly patient had mistaken a nurse for one of the porters. She told us "He was very helpful".
- Patients who we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.
- Patients in the observation ward told us that they had been consulted about their treatment and felt involved in their care.
- We spoke with three patients in the major treatment area. They all said that they had been well informed about their care and treatment. However, two of them could not understand why they were waiting so long to be transferred to a ward.

Emotional support

Urgent and emergency services

- We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nurses preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.
- There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped.

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.

There were large numbers of people arriving by ambulance and the flow of patients in the emergency department was often blocked by internal capacity issues in the hospital. This resulted in patients waiting on trolleys in a corridor before receiving a clinical assessment by ED staff. The trust had not achieved the national emergency access target to admit, transfer or discharge 95% of patients within four hours of arrival since November 2013. It was not meeting the national target to receive and assess ambulance patients within 15 minutes of arrival. There was not an adequate escalation plan to manage overcrowding in the emergency department and address these issues. There was not a single point of access for children who need emergency care as recommended by national guidelines.

Staff responded well to patient's individual needs. There was a clear understanding of the requirements of people living with dementia or a learning disability. Relatives were encouraged to stay with them whilst in the department. A specific assessment tool had been developed to assist with the treatment of people with

complex needs. There was a community team in the ED to facilitate discharge planning. Complaints were handled in appropriately and the learning was used to improve services.

Service planning and delivery to meet the needs of local people

- The staff told us the department had an escalation plan which described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances where there was an unusually high demand for services.
- When the department was full the nurse in charge was expected to inform the ED operations manager and matron. They in turn had to work with the escalation lead whose role was to ensure that there was no delay in admitting patients from the ED to the wards. We observed that ED staff followed the actions that were required.
- The escalation plan, however, did not define actions for when delay in admitting patients to a ward could not be prevented (i.e. when there was significant overcrowding in the ED). The escalation plan also did not identify the number of patients waiting on trolleys in corridors as a trigger event or risk factor. This meant that hospital wide action did not take place to meet the needs of these patients.
- In response to problems associated with a crowded department senior staff had created a major treatment queuing area. This had reduced the number of patients lying on trolleys in corridors and had improved safety. However, the physical location of this area meant that it was used as a thoroughfare by staff and visitors and so privacy and dignity for patients was compromised.
- Senior staff told us that much progress has been made in response to the CEM report "How to achieve safe, sustainable care in our Emergency Departments". However, the overwhelming numbers of patients being treated by the department had meant that it has not been possible to implement all the recommendations.
- We have reviewed a copy of the trust's improvement and recovery plan for emergency and urgent care. The purpose of this was to prevent the long delays in the ED. The plan was incomplete and appeared still to be in draft format. We briefly spoke with the project manager who was responsible for monitoring the implementation of the plan. She was able to describe the main focus of the plan but did not have information about any progress that may have been made.

Urgent and emergency services

- The hospital provides two services for children with urgent problems. Children who were already being treated by the hospital, or who had been referred by their GPs, could go to the children's assessment unit. Some preferred to go to the ED. This caused confusion and we witnessed sick children and their families being redirected to another part of the hospital. The staff told us there were plans to ensure a single point of entry for sick children but there was some uncertainty about when this will be achieved.

Meeting people's individual needs

- Ambulance patients' dignity and privacy was severely lacking when they were waiting in a corridor before being assessed by a nurse.
- Staff that we spoke with demonstrated a good understanding of the needs of patients with complex needs. There was a specific assessment tool that helped to identify immediate treatment needs.
- Nurses had received training in the care of people with a learning disability. They were able to speak confidently about the differing needs of people with a learning disability.
- The majority of staff had recently undertaken training in the specific needs of people living with dementia. All patients over the age of 75 were assessed for signs of dementia. If they were found to be vulnerable they were referred to a specialist team before being discharged.
- There was clear information about the department on the noticeboard in the reception area. This included details of the patient advice and liaison service.

Access and flow

- The hospital was regarded as "High risk" status for most of our inspection and had been on an internal "black alert" since the beginning of December 2014. There were constant lengthy delays in admitting patients to wards. Sometimes these delays were up to and over 14 hours.
- All ED departments in England are expected to receive and assess ambulance patients within 15 minutes of arrival. Queen Alexandra Hospital had failed to meet this target over the last year. The latest average waiting time that we have been given (November 2014) was 25 minutes.
- These figures should be calculated by subtracting the ambulance arrival time from the time the patient was registered on the ED computer system. However, ambulance crews were registering the patients before

they had been assessed. They told us this was necessary if they were able to leave the department in order to respond to the next call. However, this meant that the waiting times were probably worse than reported.

- We spoke with patients who were waiting in the corridor and many were concerned and anxious about waiting times and about waiting in the corridor. One person said "It's chaotic". Another said "No-one is telling us anything. We don't know what is happening next." A relative told us "Dad has been getting agitated over the length of the wait".
- The ED at Queen Alexandra hospital had not achieved the national emergency access target to admit, transfer or discharge 95% of patients within four hours of arrival. This target had not been met since November 2013. Between January 2014 and January 2015, the trust average score was approximately 85% but had been as low as 72.6% and 78.3% during September 2014.
- Approximately, 20% of patients were waited between four and 12 hours to be admitted to a ward and this was significantly above the England average of approximately 5%. The trust had a significant number of patients that breached 12 hour waits.
- There is an obvious awareness of the importance of the four hour target amongst admitting teams of clinicians and ward staff and there is evidence that they are committed to achieving it. We heard a number of conversations between admitting teams regarding how they could best admit a patient to a ward within four hours.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the patient advice and liaison service, which would formally log their complaint and would attempt to resolve their issue within a set period of time. PALS information was available within the main ED.
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant in an agreed timeframe. Learning points from complaints were discussed at ED governance meetings and at nursing staff meetings.

Urgent and emergency services

Are urgent and emergency 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.

The emergency department (ED) did not have a written strategy and appropriate actions had not been taken to reduce the risks associated with delays to patient treatment. Governance arrangements were monitoring risks and quality and there was appropriate escalation of concerns. However, medical and nursing staff expressed a sense of isolation from the rest of the hospital and were unable to resolve problems with flow without hospital support. The department did not consider it had adequate levels of clinical leadership.

Staff told us that the ED had an open and honest culture and excellent teamwork. Medical leadership was constantly visible in the clinical environment. The leadership team demonstrated the skills, knowledge and experience needed for their roles.

Vision and strategy for this service

- Although there was not a written strategy all staff that we spoke with understood the vision for the department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. They were clear about what the department did well and where it could improve.
- Senior staff told us that there was a strategy for achieving the vision. However, it had proved difficult to implement. This was mainly due to difficulties in admitting patients to wards leading to slow patient flow and a crowded department.
- The trust had sought external advice from Emergency Care Intensive Support Team (ECIST) who sent their latest report to you in May 2014. In February 2015, some actions had been taken within the urgent and emergency care departments but the inspection team

also found similar risks to those identified by ECIST in their May 2014 report. This included patients waiting too long for assessment on trolleys in corridors, and the large number of patients in the department waiting for admission to a ward. Insufficient action had been taken to address the risks of overcrowding and to improve the flow of service users from emergency department through the hospital. The improvement and recovery plan for urgent and emergency care, dated August 2014 was incomplete. The trust described progress across the health system. However, there was very little documented evidence or information about progress made.

- During our inspection the trust updated us on a five point plan to alleviate pressures in the emergency department and the hospital. This plan was still in development.

Governance, risk management and quality measurement

- Quarterly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed. Attendance was good.
- The ED maintained a risk register which fed into the hospital risk register. We saw that the top risk was “Lack of available space in ED impacting on patient assessment”. We were told that changes had been made to mitigate this risk. For example, the introduction of an ambulance streaming area and the major treatment queueing area. However, it was felt that full mitigation was outside the remit of the ED.
- Concerns had been escalated to the trust board and this had resulted in a similar risk being included on the hospital risk register. It described “Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing”. We noted that it had been on the hospital risk register since 2010 but that the risk had not reduced during that time.
- There were no risks associated with the minor injuries unit at Gosport War Memorial Hospital.

Leadership of service

Urgent and emergency services

- Leadership and management of ED were shared between a clinical services director, head of nursing and general manager. Staff told us that the leadership team had the skills, knowledge, experience and integrity required to carry out their roles.
- Governance mechanisms had been established to monitor and improve standards of patient care.
- Until 18 months ago the ED had been supported by an ED matron. However, the trust had changed the role and this was carried out by the matron for the acute medical unit. Nurses told us that they felt supported by the matron and were able to go to her if they had concerns about patient care. However, they considered that the requirements of the acute medical unit were such that it was not proving possible for the matron to give an adequate amount of time and attention to the ED.
- The head of nursing had been in post for eight months and nurses expressed admirations for her skills and experience. The head of nursing also led nursing teams in the acute medical unit and was responsible for the hospital at night. This left little time for direct patient care or clinical leadership in the ED. Despite this nurses felt that leadership in the department was proactive and trustworthy.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.
- There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff told

us that the support that they received from their colleagues in the department helped them cope with the pressure which resulted from a severely crowded department.

- The culture within the department was centred on the needs and experience of people who used the service.







Public and staff engagement

- Staff felt actively engaged by the ED leadership in the planning and delivery of services. However, all staff at all levels told us they often felt ignored by the rest of the hospital. Some expressed a sense of isolation. One said “It’s almost as if we are under siege”.
- The monthly governance meetings were attended by a patient representative. This helps to ensure that patients’ views and experiences are gathered and acted upon in order to improve the service.

Innovation, improvement and sustainability

- Learning was seen as a high priority in the ED. Shift times had been changed to ensure that there were staff teaching sessions two or three times a week. This was an example of staff and leaders striving for continuous learning and improvement.
- The department recognised and rewarded quality and innovation. There was an “Employee of the month” scheme. Staff were nominated by their colleagues and the details of each month’s winner are displayed on a noticeboard.

Medical care (including older people's care)

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

Information about the service

We inspected medical services at Queen Alexandra Hospital, which is a part of Portsmouth Hospitals NHS Trust. Queen Alexandra Hospital provides cardiology, gastroenterology, respiratory medicine, endocrinology, dermatology, general medicine and stroke services within the medical services. The hospital also provides services to elderly patients and those living with dementia. There is a 58-bedded acute medical unit (AMU) and an ambulatory care unit (ACU).

The trust also provides inpatient rehabilitation on Ark Royal Ward (20 beds) at Gosport War Memorial Hospital and rehabilitation on Cedar Ward (22 beds) at Petersfield Community Hospital.

We inspected the ACU, AMU, stroke and neuro-rehabilitation wards (F1, F2 and F3 wards), elderly care and dementia wards (G1, G2, G3, G4 and F4 wards), general and speciality medicine wards (E4, E6, E7, E8, D2, C5, C6 and C7 wards), the coronary care unit (CCU), and cardiac day unit (CDU). We also inspected Gosport War Memorial Hospital and Petersfield Community Hospital.

We spoke with approximately 35 patients, including their family members, 112 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 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, 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. These patients were reviewed by medical teams but not regularly reviewed by medical consultants. 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 care. Care was provided in line with national best practice guidance. Arrangements were in place to ensure that staff 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 coordinated way. When 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. Patients and relatives we spoke 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.

Medical care (including older people's care)

The hospital experienced difficulty meeting the demand for its medical services. Patient moves were tracked by the trust. Although the frequency and reasons were not always appropriately monitored and patient moves were not monitored at ward level. 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 achieving the 31-day cancer waiting time diagnosis-to-treatment target. The trust was not meeting the 62-day referral-to-treatment target overall. However, the target was being met in medical specialties with the exception of respiratory speciality. Integrated pathways of care had been developed in a number of medical specialties. Pathways of care were continuing to be developed and reviewed in some areas, for example in care of elderly services.

The medical clinical service centre did not have a long-term strategy but priorities were identified around improving the services. There were effective governance arrangements and staff felt supported by service centre and trust management. However, some risks were not well understood by leaders and plans to address these needed to improve. Better joined up working with other clinical service centres for example, surgery and emergency department were also identified as areas for improvement. The culture within medical services was caring and supportive. Staff were actively engaged and innovation and learning was supported. Staff from Cedar and Ark Royal wards told us that though they were located away from the main hospital, the trust leadership including the chief executive were visible on the ward.

Patients at Gosport War Memorial Hospital and Petersfield Community Hospital received effective care and treatment from caring staff. There was good local leadership of these services.

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 significant shortage of nursing staff on the medical and care of elderly wards and acute medical unit (AMU). The trust was using a high number of agency and bank nurses. However, during our night visit to the wards we found that safer staffing levels at night were not met on G4, G2 and F3 wards. Staff on the wards told us this was “inadequate” and “unsafe” for the patients because these wards had elderly patients with higher risks of falls and patients who had had a stroke that were difficult to monitor.

There were a high number of medical outliers (patients placed on wards other than one required by their medical condition) on surgical and other non-medical wards. Staff told us that patients were risk rated as red, green and amber, according to the severity of their medical conditions. Only the patients who were rated as green (low dependency) should be outliers on another ward. However, this process was not always being followed by bed management teams and patients with higher dependency and acuity needs were outliers. Patients were reviewed by medical teams although not always regularly by a consultant.

Pressure mattresses were not always readily available and this increased the risk of pressure damage to the skin in some vulnerable patients. The patients who were at high risks of falls were clearly identified and had comprehensive action plans. However, these action plans were not followed consistently and sometimes actions to minimise the risk were not taken.

Medical staffing, particularly consultant-level cover for emergency care, was appropriate. Patients were appropriately escalated if their condition deteriorated.

The trust's infection rates for MRSA and Clostridium difficile were low when compared with trusts of similar size and complexity. The environment was clean. Staff

Medical care (including older people's care)

followed the trust's infection control policy. Staff regularly washed their hands in between patients, used personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbows' policy.

Staff were encouraged to report incidents. 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.

Equipment was maintained and checked regularly to ensure it continued to be safe to use. There were daily checks of resuscitation equipment and these checks were documented.

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

Incidents

- The medical services reported 60 serious incidents through the National Reporting and Learning System for the period April 2013 to May 2014. Of these incidents, grade three and four pressure ulcers, slips, trips or falls, venous thromboembolism and healthcare-acquired infections 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. 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.
- 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. For example, the assessment and prevention of falls had changed on the medical and care of elderly wards.
- 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 intentional rounding (when nursing and healthcare assistant staff check on patients every two hours) on all the medical and care of elderly

wards. Staff did various checks on patients such as comfort checks, hydration, nutrition, continence, equipment, positioning, mobility and skin survey. The patient records we looked at showed these rounds were undertaken every two hours.

- Medical services held mortality and morbidity meetings on a monthly basis. Records of the mortality and morbidity meetings minutes showed that any death that had occurred in the department was reviewed, root causes analyses following incidents were discussed, and any lessons to be learnt were shared.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS
- Staff we spoke with were aware of the requirements of the newly introduced duty of candour regulations.
- Staff told us the trust had been proactive in introducing this new regulation. The trust had introduced training in the form of e-learning to raise awareness around duty of candour.
- The clinical staff and senior staff were familiar with the concepts of openness and transparency and could give us examples of this for managing patient safety incidents. For example, staff on the care of elderly wards gave us an example of implementing this regulation when a patient had fallen and sustained an injury.

Safety Thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls.
- 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 NHS Friends and Family Tests, numbers of complaints, levels of staff

Medical care (including older people's care)

absenteeism, mandatory training update, and numbers of patient falls, new pressure ulcers, new catheter related urinary tract infections and new venous thromboembolisms (blood clots).

- Between July 2013 and July 2014, for medical services, there had been no consistent reduction in the prevalence rate of pressure ulcers and catheter-related urinary tract infections, with periods of both reductions and then periods of increases. Between January 2014 and January 2015, the hospital had higher number of falls than the national average.
- 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 of falls by using falls risk assessment and developing comprehensive action plans. Throughout our inspection we observed that though the patients at high risks of falls were clearly identified, not all of the actions to minimise the risk were taken. For example, yellow non-slip socks and low level beds were not consistently used on all the medical and care of elderly wards.
- In response to high number of incidents related to pressure ulcers, the trust had introduced various measures such as skin care bundles, intentional rounding (where nursing and health care assistant staff regularly check on patients every two hours) on all the medical and care of elderly wards. The nursing staff also had access to tissue viability nurse.

Cleanliness, infection control and hygiene

- All of the wards we visited, including those in the Community Hospitals, were visibly clean and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and was marked as ready for use.
- Staff followed the trust infection control policy. We observed that staff regularly washed their hands in between patients, used personal protective equipment (PPE) such as gloves and aprons and adhered to the trust's 'bare below the elbows' policy in clinical areas.
- There were isolation procedures and protocols in place around the use of side rooms or cohort bays and we observed these being used appropriately.
- 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 83% of the staff across the medical services had completed hand hygiene training in the last 12 months

against the trust's target of 85%. Hand hygiene audits from July 2014 to December 2014 indicated the medical service had achieved at least a 95% compliance rate with the trust's hand hygiene standards.

- The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and for Clostridium difficile were lower when compared to trusts of similar size and complexity. Patients admitted to the hospital were screened for MRSA. Between July 2014 to December 2014, medical services did not have any case related to MRSA and had four cases related to Clostridium difficile.

Environment and equipment

- We observed that most of the medical and care of elderly wards had sufficient moving and handling equipment to enable patients to be cared for safely. Nursing staff on the wards told us that sometimes it was difficult to access this equipment, especially if it was not available from the medical library. For example, staff on G7 ward (renal ward) told us about difficulty in obtaining a hoist sling from neighbouring wards when it was not available in the medical library.
- 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.
- There were daily checks of resuscitation equipment on most of the medical and care of elderly wards and AMU, and these checks were documented.
- We found equipment such as commodes, bedpans and urinals readily available on the wards we visited.
- Staff on the AMU and medical wards told us that access to pressure mattresses was sometimes difficult. The pressure mattresses were not always readily available in the medical library and staff had to go to multiple medical wards and clinical areas to borrow a pressure mattress when required. There were concerns that delays in availability of equipment was contributing to pressure damage in some vulnerable patients. During our visit we found instances where patients did not have pressure-relieving mattresses even though they were assessed as being at risk of developing pressure ulcers. However, in the community hospitals, they had their own equipment which was sufficient for their requirements.
- The medical and care of elderly wards were designed with long corridors and multiple side rooms. Staff told

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us this environment and design had a great advantage for preventing cross infections and for patients who needed to be isolated for clinical reasons. Some staff had concerns about difficulty in monitoring confused patients or those with high risks of falls if they were in the side rooms. The staff had these concerns especially at night time when staffing levels were lower. Wards were supplied with mobile desks which could be placed in-between the patient bays and side rooms at night time. Staff told us they were trying to use the mobile desks but it was not always happening as the concept was fairly new and they needed to embed practice.

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

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges when necessary. Checks on the temperature of medicines fridges were completed daily 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 pharmacy service was good. The medical wards and AMU had a ward based pharmacist. The medical wards had support from pharmacy technicians to assess and maintain patients 'own drugs (POD). Pharmacy staff were accessible to facilitate discharges.
- Ward sisters were aware of medicine incidents which happened on their wards and the learning they took 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.
- The trust antimicrobial prescribing policy was being adhered to for outliers.

Records

- Records were in both paper and electronic format and all healthcare professionals had a combined note format. 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.
- 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. The clinical areas had allocated a safeguarding lead and the information about contacting the safeguarding lead was clearly displayed on the walls of each ward. The trust had held a safeguarding awareness week in October 2014 which the staff had found beneficial.
- Staff told us they had attended training in adult and child safeguarding. Completion rate for safeguarding training varied across each medical speciality. On average 85% of staff across medical specialities had completed 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 care of elderly ward 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.
- Training records sent to us by the trust for its medical clinical service centre showed high attendance by nursing staff on mandatory training courses, meeting the trust's target of 85% completion in almost all the

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mandatory training. Nurses and healthcare support workers we spoke with told us they had completed their mandatory training and could describe what was included in the training.

- Completion of mandatory training by medical and dental staff varied considerably by speciality. Records showed that almost none of the medical specialities were meeting the trust's target of 85% completion of all mandatory training.

Assessing and responding to patient risk

- Risk assessments were undertaken for individual patients in relation to venous thromboembolism, falls, malnutrition and pressure ulcers. 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 the 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 the AMU used the Early Warning Score (EWS), a scoring system that identifies patients at risk of deterioration or needing urgent review. These scores were recorded on an electronic device. Medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. The completed EWS charts we looked at showed that staff had escalated patients appropriately. This included medical patients on outlier wards (non-medical wards). Repeat observations were taken within the necessary time frames.
- Nursing staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- There was a critical care outreach team that supported ward staff in managing deteriorating patients. Staff across all wards stated that this service was responsive and supportive to staff and provided a high standard of clinical specialist knowledge and excellence to patients.
- There were 59 medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition). Staff told us that patients were rated as red, amber and green according to the severity of their medical conditions. Only the patients who were rated as green (low dependency) should be outliers on another ward, but this process was not being followed by bed management teams and patients with higher dependency and acuity needs were outliers.

Nursing staffing

- Nursing numbers were assessed using the national Safer Nursing Care Tool (The Shelford Group, 2014) and there were identified minimum staffing levels. The safe staffing levels were displayed at the entrance of every ward, including planned and actual numbers.
- Clinical staff as well as service leads recognised nursing recruitment as a major safety risk to the service. It was captured on the directorate risk register. The head of nursing for medicines of older people and rehabilitation services (MOPRS) told us that the nursing vacancy rate for MOPRS in September 2014 was 30%. The management team told of various measures, such as open recruitment days and overseas recruitment initiatives they had put in place in an effort to decrease the vacancies.
- At Petersfield Community Hospital, we checked the staffing rota for the month of March 2015. The safe staffing numbers were met most of the time. Additional nursing support was offered to meet patients' needs whenever required. We observed that a patient was offered 1:1 nursing support to meet their additional needs.
- Qualified nursing staff at Gosport War Memorial Hospital, were sometimes asked to work at Queen Alexandra Hospital for a shift to support staffing levels.
- When shortfalls in nursing numbers were identified, temporary staff from the National Healthcare Service Professionals or from an agency were used to try to ensure that there were adequate numbers of registered nurses to meet patients' needs. However, during our night visit to the wards we found that safer staffing levels were not met on G4, G2 and F3 wards. The wards had used a higher number of healthcare assistants in place of nurses to make up numbers. Staff on the wards told us this was "inadequate" and "unsafe" for the patients because these wards had elderly patients with higher risks of falls and patients with stroke.
- Staff told us these shortfalls in nursing numbers were not always filled, especially if staff went off sick at short notice.
- When the hospital capacity was very low, medical outlier patients were admitted into the physiotherapy gym on the F3 ward. Staff told us this had been a regular occurrence in winter months. We checked the data for the three weeks before our inspection, which confirmed that medical outlier patients were admitted to the

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physiotherapy gym. This 25-bedded ward was staffed with two registered nurses and three support workers at night. Additional resource was provided on the majority of the shifts although; despite requests for agency staff some shifts were not filled. Patients had lower dependency and acuity needs, but this could vary and staff on the wards perceived this to be “inadequate” and “unsafe” for the patients.

- Medical patients were regularly cared for on surgical or other non-medical wards. Whenever possible, staff ensured these patients were generally more stable and had lower dependency and acuity needs. However, nursing staff on surgical wards told us this was not followed consistently and often medical patients with complex needs, including patients with stroke, were transferred to these wards. Nursing staff on surgical wards told us they found it difficult to care for these patients because staffing levels were not established to take into account the complex needs of these patients.
- Staff on the medical and care of elderly wards told us they were often requested to attend other wards or the AMU when there were shortfalls in the staffing level to balance the level of risk across the organisation and to ensure patient safety.
- Senior nursing staff on the wards told us that the low staffing level meant that their supervisory role could be achieved only sometimes because they were required to fill the staffing vacancy.
- Staff told us that when patients required 1:1 care, additional agency staff were employed. We observed evidence of this on the AMU and care of elderly wards.
- Patients told us the staff and the units were busy but the nursing staff looked after them very well. Some patients told us they had to wait for a long time for call bells to be answered. A relative told us about how a patient had fallen in the bathroom when they attempted to mobilise on their own, having waited for a long time for a call bell to be answered.
- At both Gosport War Memorial Hospital and Petersfield Community Hospital, patients and relatives told us that call buzzers were answered quickly.
- 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 agency staff who already had experience of working on that ward to maintain continuity in patient care.

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

Medical staffing

- There was consultant cover on the AMU from 8am to 8pm, seven days a week. Consultant ward rounds on the AMU took place twice a day. During the day, all new patients on the AMU were seen by a consultant within one hour of their admission.
- 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 general internal medicine or acute internal medicine at level ST3 or above or equivalent staff and associate specialist grade doctors available at all times on the AMU, in line with the above guidance.
- Staff told us there were sufficient consultants and doctors on the wards during the week. In the community hospitals, there was medical cover available from a specialist doctor between 9am-5pm from Monday to Friday. If medical cover was required outside these hours the ward could contact the specialist doctor, or they could contact the acute hospital.
- 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. The medical leads told us that a high number of locum doctors filled in the gaps on the junior doctor's rota.
- Patients were seen daily by a speciality consultant on the cardiology, respiratory, gastroenterology and general medicine wards. On all the other medical and care of elderly wards, patients were seen by a consultant two or three times a week. The community hospitals patients were seen more frequently than this if required. Over the weekend, the on-call consultant saw all new patients and acutely ill patients.
- Medical patients who were on surgical wards were seen regularly by junior doctors. At weekends an additional

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locum support of SHO and FY1 was provided for the general medical team. These patients were not regularly reviewed by medical consultants. Consultant reviews at weekends were undertaken based on clinical need.

- Patients who were admitted to the acute stroke ward (F2) were seen daily by the consultants. Patients admitted to the stroke rehabilitation ward were seen by the consultant once a week or more frequently as required by their clinical need.
- All the doctors were trained in advanced life support.

Major incident awareness and training

- Staff we spoke with were aware of the procedure 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.

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.

The medical services adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. Care was provided in line with national best practice guidelines. There was good participation in national audits. Outcomes overall good were similar to or better than the England average. The trust performed below the England average in the Sentinel Stroke National Audit Programme (SSNAP). There was an action plan to address this, which had demonstrated some improvements.

Patients' pain and response to pain relief was appropriately monitored and patients were given pain relief when they needed it. 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.

Patients told us they were always given many choices and were complimentary about the quality of the food offered. Patients were supported to eat and drink when required.

Staff had access to specialist training courses and had appraisals, but clinical supervision for nurses was not well developed. The trust's mentorship and action learning programme was available to all staff.

Staff worked in multidisciplinary teams to coordinate patient care. However, staff, patients and relatives did identify the need for more physiotherapy and speech and language therapy sessions to provide appropriate care and treatment.

The trust had made significant progress towards seven-day working. There was medical consultant cover on the acute medical unit (AMU) seven days a week. There was adequate medical cover on all the medical and care of elderly wards seven days a week. Staff received a good level of training and this included training to support people living with dementia.

Discharge summaries were provided to GPs to inform them of patients' medical condition and treatment they had received when they were discharged, but this did not always happen within 48 hours and there were delays of up to two weeks before discharge summaries were sent to GPs.

Patients were consented appropriately and correctly. Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. When patients did not have the capacity to give consent to their treatment, the Mental Capacity Act 2005 was appropriately implemented.

Evidence-based care and treatment

- The medical services adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. Policies were accessible for staff and were developed in line with national guidelines, such as the pressure ulcer prevention and management policy.
- There were integrated care pathways based on NICE guidance for stroke patients. There were specific pathways and protocols for a range of conditions,

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including heart failure, diabetes and respiratory conditions. The trust had a pathway for patients with sepsis and acute kidney injury to enable early recognition, prompt treatment and clinical stabilisation.

- The endoscopy department had been awarded Joint Advisory Group 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 to measure the effectiveness of care and treatment provided. The audits included a heart failure audit, the **Myocardial Ischaemia National Audit Project**, the **Sentinel Stroke National Audit Programme** and the National Diabetes Inpatient **Audit**.
- The medical services had a formal clinical audit programme in which compliance with NICE guidance was assessed and the areas that had partial compliance were reviewed and action plans were made. Data provided by the trust showed that between July 2014 to October 2014, medical services achieved 96% compliance with NICE guidelines.
- The service conducted several local audits, such as environmental audits, audits of infection control practices and cleaning audits.

Pain relief

- Patients' pain and response to pain relief was monitored as part of their routine observations. Pain levels were scored using the Early Warning Score chart.
- For patients who had a cognitive impairment, such as dementia or a learning difficulty, staff used the 'Abbey Pain Scale' to aid their assessment. This scale was developed for patients with communication difficulties who were unable to verbalise how much pain relief they require.
- Ward staff could access support from the hospital's pain team when needed. Nursing staff on the care of elderly ward 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.
- There was a patient group directive for nursing staff to prescribe pain relief.

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 correctly to monitor patients' hydration status. Care of elderly wards and medical wards had detailed fluid balance charts informing clinical decisions.
- The Malnutrition Universal Screening Tool was used in all the wards and medical units. Records demonstrated that patients who were nutritionally at risk were referred to a dietician.
- Speech and language therapists were available on the stroke ward to check that patients could swallow safely 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.
- A red tray system was used on the AMU and all medical and care of elderly wards to identify patients who needed help with eating and drinking. We saw that all patients had access to drinks, which were within their reach. Care support staff checked that regular drinks were taken, when required.
- We observed that patients on thickened fluids did not have access to jugs of water and were given correct food.
- We visited medical and care of elderly wards at mealtime. We observed that nursing staff were helping to feed patients who needed support. Patients were given encouragement to take adequate oral fluids. . Patients were given adaptive cutlery if they required it.
- The patients told us they were always given choices for food and snack menus and praised the quality of the food offered. At Gosport War Memorial Hospital we observed patients being offered second and third portions which were accepted.
- Cedar ward had received some comments from relatives on the selection of food available to patients. The ward manager reviewed these comments and introduced additional selection of choices for patients to choose from.

Patient outcomes

- The hospital's mortality rates were within expected range.
- Staff followed care pathways for conditions such as sepsis and acute kidney injury.

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- The trust scored below the national average in most of the indicators in the Sentinel Stroke National Audit Programme between April and June 2014. The overall score for the trust was rated as 'E', which was lower than the national average which is rated as 'D'. The trust was not meeting the target for 90% of stroke patients to be cared for on the stroke unit. The stroke unit had created a comprehensive action plan and was working towards improving several measures around stroke care. These included standard discharge processes, multidisciplinary team working, specialist assessments and therapy input for patients with stroke. The trust was evaluating and monitoring the performance of the stroke wards.
- The trust had scored similar or better than the England average in most of the indicators in the heart failure audit in 2012 and 2013. The hospital had scored better than the national average in most of the indicators in the Myocardial Ischemia National Audit Project, a national clinical audit of the management of heart attack.
- The trust performance in the National Diabetes Inpatient Audit 2013 was better than the England average for 14 of the 21 indicators. Seven indicators were worse than the England average. These were foot risk assessment within 24 hours and during hospital stay, meal timings, suitability and choice of meals, staff knowledge and percentage of renal replacement therapy given to patients.
- Emergency readmissions were within expected range and the standardised readmission rates compared favourably with national rates, except for nephrology services where they were above national rates.
- 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. The trust had developed a 'training on stroke' module that was conducted twice a year, which all the staff on the stroke ward were encouraged to undertake.
- Most of staff on medical and care of elderly wards had attended dementia training. A number of staff were trained to be dementia champions. The trust had also conducted simulation workshops for dementia awareness for the ward staff.
- All the nursing staff on medical wards commented positively about the training opportunities and education packages for staff development. The staff on the medical wards told us they frequently received role-specific training, for example on pressure care from the tissue-viability nurse, central skills and communication, and nutritional study days. Staff found these training sessions helpful for their role. Nurses did not report concerns that staff shortages prevented training.
- In the General Medical Council National Training Scheme Survey 2014, trainee doctors within medical specialities overall satisfaction with training was similar to other trusts in most of the indicators. Regional teaching for trainee doctors in renal medicine speciality was rated as below national average. Trainee doctors we spoke with said they were well supported and the hospital was a safe place to work.
- The trust had recently recruited clinical practice educators who were helping clinical staff on the medical and care of elderly wards to build up training-specific competencies.
- The therapy staff on the medical wards told us that they attended in-service training once a month and the junior physiotherapy staff also received weekly teaching related to their speciality. Therapy staff in the community hospitals had in-service training sessions and also had an opportunity to attend training and peer review sessions at the Queen Alexandra Hospital.
- 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.

Competent staff

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.
- Staff told us they had regular annual appraisals but did not receive formal supervision. The trust's mentorship and action learning programme was available to all staff. Appraisal figures in the medical speciality were approximately 91% for medical staff and 74% for nursing staff. The latter was lower than trust targets.
- Nursing staff were supervised during their clinical practice and said that handovers, ward rounds and board rounds provided them with learning opportunities.

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Multidisciplinary working

- There was evidence of multidisciplinary working on all medical and care of elderly wards and the AMU, which included physiotherapists, dieticians, occupational therapists, speech and language therapists and social workers.
- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Multidisciplinary team 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. The patients on the acute stroke ward (F2) were also referred to clinical psychologists if necessary.
- Speech and language therapists attended the stroke wards, but the nursing and therapy staff on these wards told us that more input was needed from the speech and language therapy team because patients would benefit from more regular and enhanced input from this team. The performance of this team was rated as 'E' on the Sentinel Stroke National Audit Programme (April 2014 to June 2014), which indicate the worse scores below the average.
- Multidisciplinary Team Meeting (MDT) meeting took place on Cedar 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, and social worker.
- Patients' records across medical services showed they were referred, assessed and reviewed by physiotherapists, dieticians and the pain team. However, patients, relatives and physiotherapists did identify the need for more physiotherapy sessions to provide appropriate care and treatment.
- There was dedicated pharmacy support on all the wards we visited.
- The hospital did not have a dementia specialist nurse role in post and there were plans to develop this post. On medical and care of elderly wards, patients living with dementia were assessed and reviewed by medical and nursing team.
- There was medical consultant cover on the 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 elderly wards we visited, consultant ward rounds took place at least twice a week. Over the weekend, all new and deteriorating patients were seen by the on-call care of elderly consultant.
- The patients on the coronary care unit 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 and were seen by the on-call consultant over the weekend.
- Consultants worked seven days a week across all the medical wards. Patients who were admitted to the acute stroke ward (F2) were seen by the consultants daily. Patients admitted to stroke rehabilitation ward were seen by the consultant once a week. The on-call stroke consultant would see new admissions on the stroke ward and would take a ward round over the weekends. The transient ischaemic attack clinic was accessible seven days a week.
- There was a daily consultant gastroenterologist on-call for emergency gastrointestinal (GI) bleeding patients. There was a seven-day endoscopy service available for GI bleed patients.
- A seven-day physiotherapy service was available for patients with respiratory conditions between 9am and 8pm, as well as on-call at night.
- The medical services had access to radiology support seven days a week, with rapid access to CT scanning when indicated.
- The pharmacy department was open seven days a week, but with limited hours on Saturday and Sunday. An on-call pharmacist was available to dispense medicines over the weekends.
- Medical patients who were on surgical wards were seen regularly by junior doctors. These patients were not regularly reviewed by medical consultants.

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. All areas used electronic handover sheets to ensure all staff had up-to-date information about patients on their ward.

Seven-day services

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- Staff told us when the patient was transferred from the AMU to a ward; staff could access a 'patient transfer summary' from the computer. Nursing staff told us this was sometimes not available, especially when the patient move took place late during the day or at night. This meant patients were not always handed over safely. We saw an example of this on G2 ward (care of elderly ward) during our night visit. Staff on this ward told us that a patient who was transferred from the AMU on that night needed to be isolated in a side room because of infection control issues. This information was not handed over to the ward staff before the patient was transferred. The ward was not able to accommodate this patient in a side room because of its capacity. Ward staff were left with the responsibility of contacting other medical and non-medical wards to find a side room for this patient.
- Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received. However these were not always sent within 48 hours and there were delays of up to two weeks before discharge summaries were sent to GPs. This meant that GPs were not always aware about their patient's discharge and could not offer adequate community support if required.
- The trust had an electronic vital signs monitoring and early warning score tool for use by nursing and medical staff. This was also linked to the on-call medical team's list. This was seen as essential to ensuring patient safety on wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. When 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 and Deprivation of Liberty Safeguards.
- We saw that when 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 elderly medicine wards for 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 observed an example on C5 ward (medical ward) during our visit when an application of Deprivation of Liberty Safeguards was considered and a restraint policy was applied for a patient. The ward staff had followed the entire process appropriately and there was close involvement of the mental health and adult social services teams, and progress was monitored.

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 and their relatives were treated by staff with compassion, dignity and respect. The staff focused on the needs of patients and patients told us doctors, nurses and healthcare assistants were caring, compassionate and responded quickly to their needs. Some patients on the medical wards told us the call bells were not always answered promptly and patients had to wait a long time for assistance. However, this was not the case at both Gosport War Memorial Hospital and Petersfield Community Hospital, where patients told us their call buzzers were "almost always" answered quickly.

Patients and relatives we spoke with said they were well informed and involved in the decision-making process regarding their treatment. The therapy and nursing staff on the stroke wards arranged family meetings with patients' relatives within two weeks of patients' admission. These meetings involved discussions about patients' progress, goals and their involvement in care. The community hospitals used this "two-week" approach also.

During our inspection we observed that staff were responsive to patients' needs, and we witnessed multiple episodes of kindness from motivated staff towards

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patients and their relatives. Therapy staff on the stroke unit assessed patients using a 'mood assessment pathway' and patients were referred to a clinical psychologist appropriately.

Compassionate care

- Results of the NHS Friends and Family Test were displayed on every ward, and there were posters encouraging patients to give their feedback so that the care provided could be improved. Overall the results showed satisfaction with the service provided. The average trust score for medical wards was above the England average. All medical wards scored higher than the England average.
- The 2013 CQC Inpatient Survey found the trust scored similar to other trusts on all the indicators.
- The 2012/13 and 2013/14 Cancer Patient Experience Survey found the trust scored similar to other trusts on 30 out of 34 indicators, better than the other trusts for two indicators and worse than the other trusts for the remaining two indicators.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- 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.
- Patients in Petersfield Community Hospital told us the staff were very patient and gave them time to work towards their rehabilitation goals. For example, one patient told us how she was motivated and encouraged by the staff to walk using the walking frame after she had given away hopes to be able to stand on her feet again. She described the staff as 'angels' and was very pleased with the progress she had made in the ward.
- Another patient told us about the progress he had made following the amputation of his limb. He said that he had set goals for himself with the therapy staff. He talked about how staff had motivated him to work towards the goals. He felt that he was given enough time and was not rushed for discharge.
- However, some of the patients we spoke with on the stroke and neurorehabilitation wards (F2 and F3) and

care of elderly wards (G3 and G4) told us the call bells were not always answered promptly and patients had to wait a long time for assistance, for example with personal care needs or to go to the bathroom or toilet.

- The trust had introduced intentional rounding when nursing and healthcare assistant staff check on patients every two hours) on all the medical and care of 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. Intentional rounding was inconsistent on the acute medical unit.
- We observed staff speaking with patients and their relatives in a caring and compassionate manner, providing reassurance and support.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke 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. Patients had been given the opportunity to speak with their allocated consultant.
- Both patients and their relatives commented that information was discussed in a manner they understood. Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care.
- 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.
- 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. The therapy and nursing staff on the stroke wards arranged family meetings with patients' relatives within two weeks of patients' admission. These meetings involved discussions around patients' progress, goals and their involvement in care. The relatives we spoke with commented positively about these meetings and found them a very useful source of information.

Emotional support

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- 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.
- A relative on one of the elderly care wards told us the staff had encouraged them to visit at lunchtime to assist with feeding their father, who was very anxious and confused. This additional support had helped in reducing the patient's anxiety and confusion.
- At Gosport War Memorial Hospital, a relative and patient sought the inspection team out, specifically to inform them of their satisfaction with the care and emotional understanding that had taken place on Ark Royal Ward. They said this emotional care extended to the family, as well as to the patient, and that the nursing medical and therapy teams actively worked together to provide a high and consistent level of emotional support.
- Therapy staff on the stroke unit assessed patients using a 'mood assessment pathway' and patients were referred to a clinical psychologist appropriately.

Are medical 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.

The acute medical unit (AMU) and ambulatory care unit (ACU) was introduced to improve the trust's ability to manage the increasing pressures on beds because of an increasing demand. However, many patients stayed in the AMU longer because it was difficult to transfer them to the speciality wards because of capacity issues. This also meant that patients had to wait longer in the emergency department (ED) before they could be transferred to the AMU. Integrated pathways of care had been developed in a number of medical specialities. Pathways of care were continuing to be developed and reviewed in some areas, for example care of elderly services. There were outreach clinics in respiratory and cardiology to support community rehabilitation. An enhanced physiotherapy project had demonstrated reduced length of day stay for the elderly but had stopped because of funding issues.

Bed occupancy in the trust was consistently above the national average. There were 59 medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition). These patients were not always reviewed by medical consultants in timely way. Some patients were moved between the wards several times, including at night. There was a system to track the number of times patients move wards. Patients told us that they have been moved multiple times and had been seen by different staff, which had an impact on continuity of care.

The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target. The trust was not meeting the 62-day referral-to-treatment target overall. The target was being met in medical specialties with the exception of respiratory speciality. The medical services were consistently achieving the 18-week referral-to-treatment time target against a national target 90%.

Cedar ward at Petersfield Community Hospital undertook an audit of delayed discharges in 2013. Fifty six percent patients were noted as delayed discharges. As a result, they introduced a team of healthcare professional to undertake discharges and a new process to streamline their discharge procedures. A re-audit in 2014 reduced the number of delayed discharges to 8%.

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.

Complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service if they were unable to deal with their concerns directly and advised them to make a formal complaint. Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved.

Service planning and delivery to meet the needs of local people

- The 58-bedded AMU was open 24 hours a day, seven days a week. The unit was divided into different bays, which were colour coded, and also included a six-bedded escalation area where patients with low medical dependency were admitted. Staff told us the unit was always busy and had alleviated some of the pressures in the emergency department (ED).

Medical care (including older people's care)

- Emergency admissions to medical care services represented the majority of admissions. These were primarily through the ED or GPs. Patients were initially admitted to the AMU for assessment and diagnosis of their condition with a maximum stay of 24 to 48 hours. If a longer stay was required, patients were transferred to the relevant speciality ward. However, because of bed pressures patients were frequently cared for in the AMU for longer periods.
- The leads within the service were aware of concerns related to access and flow of medical patients from the AMU to medical wards and were monitoring multiple bed moves. However, we found that the severity of these problems were not well understood and there were not robust plans in place to address concerns.
- The patients admitted in the AMU were regularly seen by speciality doctors such as respiratory, cardiology or care of elderly consultant, as required. The unit had been staffed with a locum physiotherapist and a locum occupational therapist since January 2015. Before this, there had been no ward-based therapist on the unit.
- The hospital had a consultant-led Ambulatory Care Unit (ACU) where patients could be admitted through several different routes, including GPs. This unit was open seven days a week, between 8am and 9pm. The unit followed specific ambulatory care pathways for assessment of deep vein thrombosis, pulmonary embolism and intravenous antibiotic treatment, which formed 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 service leads told us that the trust was engaging with its community healthcare partners such as Solent Healthcare NHS Trust and Southern Health NHS Trust as well as with local authorities to develop an integrated care pathway for care of elderly patients. The aim was to develop collaborative working and safer discharge pathways across acute and community healthcare providers. The leads told us that the engagement with these partners needed to improve to obtain the desired outcome.
- The respiratory and cardiology department had developed outreach clinics at Fareham Community Hospital and Gosport War Memorial Hospital for

patients with long-term respiratory and cardiology conditions. They had also developed community rehabilitation exercise classes with the aim of reaching out to patients in the community.

- The therapy staff had launched an 'enhanced physiotherapy project' on selected care of elderly wards between December 2013 and June 2014. As a part of the project patients were offered an intensive therapy programme and worked towards long-term rehabilitation goals. This project had succeeded in reducing length of inpatient stay and also in reducing the number of new nursing or care home placements. Therapy staff told us that this project could not continue after June 2014 because of funding issues.

Access and flow

- Bed occupancy in the hospital was consistently above 91%. This was 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.
- There was a trust-wide operational group responsible for the coordination 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. They also discussed any action that was required when wards were at full capacity.
- Senior nursing staff on all the medical and older people wards and AMU attended bed management meetings three times a day. These meetings enabled managers and staff to get updated information on the activity in the ED and the availability of beds on ward areas. This information helped staff to manage patient flow from the AMU to speciality wards but bed occupancy levels impacted on decisions.
- The average length of stay in the AMU was aimed to be 24 to 48 hours. However, staff told us that this was frequently not achieved and many patients stayed in the AMU for four days or longer because it was difficult to transfer these patients to the speciality wards because of capacity issues. This also meant that patients had to wait longer in the ED before they could be transferred to the AMU.
- Staff in the ED identified that medical patients were not always seen in a timely way and this impacted on the flow of the emergency admissions through the

Medical care (including older people's care)

department. During our inspection we found medical patients in the majors area who had remained there overnight and the post take ward round was being done by the ED consultants.

- There were 59 medical outliers at the time of our inspection (patients placed on wards other than one required by their medical condition). The number of outliers varied each day. In January 2015, the number of medical outliers had reached to 98. We visited surgical wards that had medical outliers. Medical and nursing staff raised concerns about medical outliers. They said many surgical wards routinely had high numbers of medical patients and that these patients were reviewed less regularly by doctors from medical wards. Staff said they often had difficulty locating speciality doctors, for example, cardiology or respiratory doctors who needed to review their patients. Action was being undertaken to ensure patient records included their consultant names so that consultants could track patients more effectively. There was no process to ensure all patients were tracked and for consultants to undertake regular ward rounds for outliers.
- Staff told us that bed moves happened all the time and there was no robust system to track the number of moves. Patients told us that they had been moved multiple times and seen by different staff, which had an impact on continuity of care. We visited A6 (gynaecology ward), which had eight medical outliers at the time of inspection. All of these patients were living with dementia and were awaiting discharge. Some of these patients were moved three or four times between different wards.
- Patient records showed patients living with dementia were moved late at night. Staff on two different wards described occasions where this had caused patients who were moved to become agitated, confused, and aggressive. Staff were also concerned that where patients who were moved became agitated, particularly at night, this disturbed other patients around them. A patient with dementia who should have been on an elderly care ward was being cared for on the renal transplant ward unit while waiting for a care home placement. A high risk emergency patient was placed on the private surgical ward rather than on an acute medical ward, which would have been more appropriate for the patient's condition. Medical patients receiving end of life care were mixed with surgical patients on a general surgery ward.
- We visited E4 ward (a medical step down ward), E2 and E3 wards (surgical wards) and A6 (gynaecology ward), where medical patients were outliers. Staff on the surgical wards told us they spent a long time tracing the medical team to review these patients and these patients were not regularly reviewed by medical consultants. Medical consultants did "safari" ward rounds to multiple wards to see the medical outliers. This meant that medical reviews and discharge planning could be delayed.
- Patients were admitted to the gynaecology ward from medical wards when beds were required for sicker patients. The staff on these wards liaised closely with the doctors from the medical ward who retained responsibility for the patient. Any concerns were escalated to the matron for medicine. We saw evidence of this within the operations meeting minutes where staff had escalated concerns regarding the lack of medical care of a patient admitted from a medical ward. Patients we spoke with who had been transferred to the gynaecology ward were full of praise for the treatment and care they had received.
- The trust did not have performance data on patient moves specified for each clinical service centre. The trust's integrated performance report from January 2015 showed that in January there was a total of 228 patient moves which took place between 11pm and 6:59 am. Medical patients formed a high proportion of this total. The report noted the number of patient moves across the trust had increased by 37 moves since the previous month. This was attributed to capacity pressures.
- Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. Discharge coordinators supported ward staff in planning complex discharges. Discharge arrangements were discussed at the daily board rounds.
- Cedar ward at Petersfield Community Hospital undertook an audit of delayed discharges in 2013. Fifty six percent patients were noted as delayed discharges. As a result, they introduced a team of healthcare professional to undertake discharges and a new process to streamline their discharge procedures. A re-audit in 2014 reduced the number of delayed discharges to 8%.
- The data provided by the trust demonstrate that between July 2014 and October 2014, there were a high number of delayed transfers of care. Delayed transfer of care is when patients are in hospital and are fit to be discharged but can't leave the hospital because of

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external factors. We were told that the main cause of delays was the provision of community services, especially care home places, to meet patients' ongoing needs. The trust was working with its partners to alleviate this problem. National data published by NHS England (December 2014 to January 2015) demonstrated that the trust had a comparatively smaller number of delayed discharges compared with other similar trusts.

- The trust was engaged with partner organisations such as Southern Health NHS Foundation Trust and Solent Healthcare NHS Trust in managing discharges and care pathways.
- The trust had a discharge lounge where patients could await transport or final discharge arrangements such as medicines. The discharge lounge was open Monday to Friday between 8am and 7.30pm and over the weekends between 9am and 5pm. Patients we spoke with in the discharge lounge felt that they were looked after well by the nurses and support workers. We observed patients in the discharge lounge regularly checked by the nurses to ensure their comfort and offered meals. Staff told us that patients sometimes waited for up to four hours for transport to arrive. Staff always waited with the patients until they were discharged from the hospital.
- Between May 2013 and May 2014, the service centre was consistently achieving the 18-week referral-to-treatment time target against the national target 90%. The compliance rate for general medicine, nephrology and geriatric medicine was 100%.
- From April 2014 to January 2015, the trust met the 31-day cancer waiting time diagnosis-to-treatment target. The trust had met the 62-day waiting time target from referral to treatment up to December 2014. This target was not met in January to March 2015.

Meeting people's individual needs

- There was support available for patients living with dementia or with a learning disability, and for staff caring for these patient groups.
- The trust did not have a dementia specialist nurse in post. We were told by the dementia lead nurse that there were plans to review the role of a dementia specialist nurse in the near future. The trust had trained a number of staff to become dementia champions on the medical and care of elderly wards who could offer support and advice to patients living with dementia.

- Staff were able to access support and advice from learning disability nurses, who were employed by Solent Healthcare NHS Trust on week days for individual patients. Staff demonstrated an awareness of the 'Care Passport' scheme, in which patients with a learning disability brought a document outlining their care needs and preferences and information about them for staff to consult. The trust did not have any 'flagging' or 'alert' system in place when these patients were admitted to the hospital. The learning disability nurses had to rely on the ward staff or the family members for individual referrals.
- 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. However, this was not used consistently for all the patients living with dementia. On the care of elderly wards we saw some examples of when patients living with dementia had the booklet and it was appropriately completed. We also saw several examples where the 'this is me' booklet was not used for patients living with dementia.
- All patients over 75 years were screened for dementia using a recognised methodology on their admission. Staff had completed basic dementia awareness training. The trust had developed a 'dementia care bundle', which assisted staff to meet the needs of these patients.
- The staff on the care of elderly wards held a 'memory lane' service for patients living with dementia once a week. This included engaging patients in remembering their past times by means of music, games, reading material and communication. We observed that patients were enjoying these activities and engaging with staff and other patients. Relatives were also encouraged to join this service. Relatives told us this service provided a good emotional support to patients living with dementia and made them feel the hospital was a homely environment.
- However, patients living with dementia did not always receive the specialist support they needed. We found medical patients living with dementia were on many of the surgical wards. For example there was a medical patient living with severe dementia who had been on the renal transplant ward for a week and who was waiting for a care home placement.
- There was an arrangement with the local NHS mental health services to provide a liaison service for people

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with a learning disability and mental health disorders. We observed a consultant psychiatrist who was employed by Southern Health NHS Trust visiting F1 ward to assess patients who were diagnosed with a mental health disorder.

- Staff on the AMU told us that visiting hours for carers of patients with mental health problem 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.
- A wide range of patient literature was displayed in the clinical area covering disease and procedure-specific information, health advice and general information relating to health and social care and services available locally. Patient information leaflets were not displayed in languages other than English.

Learning from complaints and concerns

- Staff understood the hospital's complaints policy and knew how to manage any complaints they received. They said they would try to resolve any concerns or complaints that a patient might have before they escalated into a formal complaint. Information about complaints processes were displayed in the ward/unit areas.
- Staff directed patients to the patient advice and liaison service 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.
- Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved.
- Patients and relatives we spoke with did not always know how to complain to the hospital and said that they would voice concerns or complaints directly to the nurse in charge of the shift or the nurse caring for them. They were confident that concerns and complaints would be treated seriously and dealt with promptly.

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 medical clinical service centre did not have a long-term strategy but priorities were identified around improving the services. The medical and care of elderly service leads told us their priorities included improving the patient journey, treating patients in the most appropriate area and making sure that patients receive the right care in the right place.

There was a governance structure to manage risk and quality. Staff felt supported by their ward and line managers. There was strong local leadership on the medical and care of elderly wards. However, the risk of outliers, patient flow and patient bed moves identified by ward staff were not well understood by leaders and plans to address this needed to improve. Better joined-up working with other clinical service centres for example, surgery and the emergency department were also identified as areas for improvement.

Staff said that the leadership and visibility of managers in the medicine was good. Staff from the community hospitals were positive about their local leadership and the trust leadership team. They felt involved with the trust.

The culture within the service was caring and supportive. Staff were actively engaged. Innovative ideas and approaches to care were encouraged and supported.

Patients were engaged through feedback from the NHS Friends and Family Test and complaints and concerns. A 'coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education.

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Patients were also given information about support available in the community. Clinical governance meetings showed patient experience data was reviewed and monitored.

Vision and strategy for this service

- The clinical service centre did not have a long-term strategy but priorities were identified around improving the services. The medical and care of elderly service leads told us their priorities included improving the patient journey, treating patients in the most appropriate area and making sure that patients receive the right care in the right place.
- The leaders were committed to making stronger links with community services to ensure appropriate care was provided on discharge, especially for patients with long-term conditions and complex frail elderly patients. The staff we spoke with were not aware of the service's strategy.
- The trust's vision was well recognised and owned by staff. Matrons and ward sisters and therapy staff were passionate about improving services for patients and providing a high-quality service.

Governance, risk management and quality measurement

- The medical services had a quality dashboard for each service. It showed how the services performed against quality and performance targets. Members of staff told us that these were discussed at team meetings and there were actions identified for targets that were not met. The ward areas had visible information about the quality dashboard.
- The medical service had monthly clinical governance meetings where the results from clinical audit, incidents complaints and patient feedback were discussed and shared with staff. Minutes of clinical governance meetings showed patient experience data were also reviewed and monitored.
- The clinical governance team collated data and produced a report for the service each quarter. Included in this report was a review of incidents, review of the risk register, general patient safety information, infection control review, and information about clinical and non-clinical claims, training, and morbidity and mortality reviews.

- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. If staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The service had a risk register that included all known areas of risk identified in the medical service. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated.
- We found, however, a disconnect between the risks and issues described by staff and those reported to and understood by leaders of the service. These risks mainly regarded outliers, patient flow and multiple bed moves. The severity of these concerns described by the ward staff was not well understood by the leaders and the action taken was not addressing the issues identified.

Leadership of service

- Leadership and management of medical services were shared between a chief of service, head of nursing and general manager. There was a clinical director, lead Nurse and business service manager for each sub-speciality. Each ward had a manager who provided day-to-day leadership to members of staff on the ward.
- Staff in all the clinical areas across the medical services spoke highly about and had confidence in their local leaders, who included matrons, ward managers and lead consultants. Staff across medical wards told us matrons were visible and had a regular presence on their ward.
- Staff told us that they felt supported by their line manager to do their jobs well despite challenges, especially of capacity and recruitment. Staff of all grades were aware of the challenges faced by the service and were aware of, and engaged with, actions to mitigate the effects of quality and safety of care.
- The head of nursing for MOPRS had been in post for eight months. Staff told us that the head 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 service and the trust.
- The student nurses told us they felt supported on the ward and received supervision training from the senior staff.

Medical care (including older people's care)

- Patients reported that they felt the service was well-run. For example, one patient told us, "I think the bosses are doing a good job. All seems well managed and organised to me."
- Staff from Cedar and Ark Royal wards told us that though they were located away from the main hospital, the trust leadership including the chief executive were visible on the ward. The new director of nursing had recently visited the wards in February 2015.
- The leadership team on Cedar ward met weekly to discuss incidents, complaints and comments from patients, relatives and staff. The ward highlighted actions taken as a result of comments.
- Staff we spoke with on Cedar ward felt that the ward leadership team was visible and that they enjoyed working on this ward. One person told us: "It feels like working with friends and you are taking care of each other's family members."
- The matron with overall responsibility of Ark Royal and Cedar wards visited on a monthly basis and staff said she was very approachable.

Culture within the service

- Staff on all wards spoke positively about the service they provided for patients. They said there was an open and transparent culture that focused on meeting patient needs.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents and were also aware of areas they needed to improve.
- 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.
- However, staff felt that there was not much engagement and integrated working between different clinical service centres, such as between medicine and emergency medicine and between medicine and surgery. There was a sense of service centres working in isolation.

Public and staff engagement

- The trust ran a 'listening into action' programme where staff shared their views about what would make the biggest difference to services. Themes were identified regarding 'what matters to staff' and 'making things







better for patients'. The nursing staff told us they found these engagement sessions helpful. Staff told us they made them feel valued because their views were listened to by the trust's management.

- 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 the NHS Friends and Family Test and complaints and concerns.
- The clinical service centre also held a 'dementia café' and 'memory café' on a weekly basis to engage patients and their carers. The neuro-rehabilitation ward (F1) and stroke wards (F2 and F3) held a 'breakfast club' in the ward for patients. This was to promote patients' independence and also incorporated social interactions and therapy sessions.
- A 'coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education. Patients were also given information about support available in the community.
- Clinical governance meetings showed patient experience data were reviewed and monitored. We did not find any other methods of patient and public engagement used.

Innovation, improvement and sustainability

- There were many innovative practices developed in the medical service to support the improvement and sustainability of the service. This included the trust's use of electronic prescribing, a ward-based pharmacist and 'Vital Packs' (an electronic clinical information system used by the trust to gather inpatients' vital signs data).
- The Diabetes and Rheumatology teams had won national awards for innovations in practice.
- The service leads acknowledged that cost improvement was becoming more difficult because the service growth figures were high because of the increase in the number of patients, especially unscheduled care. This had put a substantial financial challenge on the service. The leaders told us that the safe staffing levels would come with a cost and the use of agency staff had an impact. The service leaders were working collaboratively with financial partners and had identified a range of cost improvement plans. Appropriate risk assessments had been carried out to understand the potential risks of cost improvement plans to quality and safety.

Surgery

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

Information about the service

Portsmouth Hospitals NHS Trust offers emergency and elective surgical procedures on an inpatient basis as well as day case surgery. Surgical specialities include general surgery, cancer surgery, trauma and orthopaedics, plastic surgery, ophthalmology, urology and bariatric (weight loss) surgery, vascular, ENT, breast, endocrine, upper gastrointestinal, colorectal, max fax, and emergency surgery. Queen Alexandra Hospital, which is the trust's main site, also offers robotic colorectal surgery and is accredited as a training hospital for robotic colorectal surgery.

There are nine surgical wards, a surgical assessment unit, a surgical high care unit and a separate kidney transplant ward. There are 28 theatres divided between two theatre complexes on two different levels, including four endoscopy theatres. The hospital's paediatric theatres are reported on in the services for children and young people section of this report. There is a private surgical ward that provides care for private patients who have had surgery.

We visited both theatre complexes, including pre-operation assessment clinics, theatre admission areas, theatre and recovery areas, and radiology services. We also visited a number of wards, including wards E1 (surgical assessment unit), E2, E3, D1, D3, D5, D8, G9 (renal transplant), G5 (private surgical ward) and the surgical high care unit.

We spoke with 30 patients, five relatives and 90 members of staff. These included nursing staff, healthcare support workers, ward clerks, junior and senior doctors, pharmacists, physiotherapists, operational support staff,

and managers. We observed care and treatment and looked at 43 care records, including medication charts and pain management records. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Surgery

Summary of findings

We found that while staff were compassionate and caring and outcomes for patients were generally above the England national average, improvements were required to ensure safe, responsive and well-led treatment and care for patients. Incidents were usually reported and learning from these was shared with staff. Overall standards of cleanliness were good, although there were exceptions in relation to hand hygiene practices on some of the wards we visited. Sufficient equipment was not always available to meet patients' needs.

The five steps to safer surgery checklist was completed but its documentation needed to improve. Electronic monitoring was used on surgical wards to identify patients at risk of deteriorating. However, staff in theatres did not consistently use an early warning tool to identify deteriorating patients.

Staff were not aware of standardised protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness of patients for day case surgery. There was a high take up of mandatory and statutory training by nursing staff but trust records showed poor take up of this training by surgical and dental staff. Risks to patient care were identified and escalated but were not always resolved in a timely manner, particularly in relation to theatre facilities. There was a shortage of nursing staff across the service as well as a shortage of anaesthetic staff.

Emergency surgery was managed in line with national professional requirements. Clinical audit was used to monitor compliance with evidence-based national guidelines and best practice. Patients' needs were assessed, monitored and addressed. Patient outcomes against a number of indicators were better than the England national average. Mental capacity assessments were undertaken by surgical staff. However, ward staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

There were sometimes not enough beds for the number of patients requiring them. Patients were not always put on wards best suited to meeting their requirements for

specialist treatment and care. The national referral to treatment time target for 90% of patients to have surgery within 18 weeks was not met overall, although this was a planned fail in agreement with Commissioners to address patients on the waiting list. Capacity issues within the hospital resulted in elective procedures being cancelled.

The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target. The trust was not meeting the 62-day referral-to-treatment target overall. The target was not being met in head and neck, lower GI and urology surgical specialties.

There were clear clinical governance arrangements. Performance against operational and quality targets was monitored and action was taken when performance fell below expectations. Key risks were identified and escalated to the trust's risk register. However, staff across a number of wards raised concerns about not being able to escalate risks beyond ward level. Risk registers did not always identify how risks were being managed and many interventions were out of date. Staff were also concerned that disciplinary action was sometimes being instigated unfairly.

Surgery

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.

Infection prevention and control practices were not being followed in relation to hand hygiene practices on some wards. Infection control arrangements in the surgical high care unit did not meet professional recommendations. Sufficient equipment was not always available to meet patients' needs and there was a shortage of intravenous infusion pumps, drip stands and pressure-relieving mattresses.

Staff were not always aware of standardised protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness of patients for day case surgery. The five steps to safer surgery checklist was being used and electronic monitoring on surgical wards was used to identify patients at risk of deteriorating. However, this was not always fully documented and the early warning score for assessing deteriorating patients was not always used in theatre. Patient records were not always stored in a way that ensured confidentiality. There was a high take up of mandatory and statutory training by nursing staff but not by surgical and dental staff. Risks were identified and escalated but, in theatre, were not always resolved in a timely manner.

There was a shortage of nursing staff across the service and safe staffing levels were not always met on some wards. This meant patients did not always receive the care or assistance they needed when they needed it. The nursing handover on ward E3 did not escalate or prioritise patients appropriately. There was seven-day consultant cover across the service and patient records showed patients were seen by consultants during the weekend. However, there were vacancies at consultant level with a need for further anaesthetic staff. The trust was recruiting for these.

Incidents were usually reported, although we found exceptions on one ward. Learning from incidents was shared with staff. National data (Safety Thermometer) showed the number of falls, urinary tract infections and pressure ulcers was better (lower) than the English average.

However, trust data showed an increase in patients developing pressure ulcers in surgery and cancer. There was also an increase in trauma, orthopaedics and rheumatology but were classified as unavoidable pressure ulcers.

Incidents

- Surgical services reported two Never Events since October 2013, both involving wrong site surgery in dental outpatient procedures. A Never Event is defined as a serious, largely preventable patient safety incident which should not occur if the available preventative measures are correctly implemented. The two patients involved were informed of the incidents and the trust's records indicated patient outcomes were not affected. A full root cause analysis was undertaken in each case and staff told us what had changed as a result, for example, changes were made in cross-checking treatment plans before surgery. A third potential Never Event was brought to our attention during our visit involving the insertion of the wrong size optical lens during eye surgery. The incident was under investigation.
- Nurses, healthcare support workers and doctors were able to describe changes that were made as a result of incidents. For example, theatre staff were able to tell us about changes to the trust's surgical safety checklist that were made as a result of a surgical Never Event.
- Staff involved in cataract surgery told us about new procedures they had implemented following an incident where a patient had received the wrong size lens. Nursing staff told us about remedial training that had been provided following the reporting of incidents. Pharmacy staff told us about an incident when a patient's medicines were left in the ambulance that transported the patient home and how pharmacy staff had responded.
- Staff across all but one of the areas we visited told us they were encouraged and supported to report incidents. Managers described the processes they used to investigate incidents and how they used investigation findings of incidents to inform their quality assurance processes.
- Staff on individual wards and in theatres told us they received feedback from incidents they reported and that learning points from incidents were shared at staff team meetings. However, Ministry of Defence staff told us they did not attend team meetings and were not sure how information about incidents was shared with them.

Surgery

- Although there was evidence of learning from incidents, learning from incidents that took place on individual wards was not consistently shared across the hospital. There was a staff newsletter that highlighted lessons learned from across the trust and some staff told us they received emails that identified learning points from incidents. However, most of the staff we spoke with were not aware of learning points resulting from incidents in other areas of the trust.
- On ward E3, we looked at the trust's electronic incident reporting system and saw incidents were reported. However, we found a number of incidents relating to pressure ulcers had been reported using a paper-based system. These incidents were not transferred onto the electronic incident database. When asked, staff told us the paper-based incident reports had not been included in the ward's official incident reports.
- There were a high number of incidents related to grade two and three pressure ulcers, which the trust recognised and had taken steps to address. Staff in all the areas we visited were aware of the need to reduce the number of pressure ulcers and could tell us what they did to prevent patients developing pressure ulcers. Incidents relating to pressure ulcers were monitored at clinical governance meetings and at board level through board reports. Staff told us actions taken to reduce the number of pressure ulcers included roll out and checks of compliance with skin care bundles, individual training and access to a tissue viability nurse. With the exception of ward E3, staff also told us there was increased monitoring and scrutiny, by managers, of reported pressure ulcers.
- Serious incidents requiring investigation were reported, investigated and escalated to senior management. Staff described serious incidents that had happened on their ward and staff who were involved in serious incidents were able to describe their involvement in panels where serious incident investigations were discussed. Serious incidents requiring investigation were escalated to the trust board and monitored through monthly and quarterly board reports and integrated performance reports. Learning points from serious incidents were shared with the board as an appendix to board quarterly quality reports.
- Morbidity and mortality meetings were used across surgical specialities to review incidents and unexpected deaths in order to identify learning and improve

services. Senior and junior doctors told us that monthly mortality and morbidity meetings were used to discuss complications and learning points where patient care could have been better.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS.
- Staff told us they were provided with training on the duty of candour. On some of the wards we visited, we saw posters explaining the principles underpinning the duty of candour and what was required in order to comply with the duty.
- Staff we spoke with understood their responsibilities with regard to the new duty of candour legislation. Staff in almost all areas we visited told us incidents involving potential mistakes in patients' care or treatment were investigated and findings were shared with patients, and where appropriate, their relatives. They also described the need for patients involved in incidents to be given an apology.
- Staff were aware that although the process of investigating incidents and potential mistakes was not a new one, the duty of candour now made it a legal requirement.

Safety Thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. Patients, visitors and staff could access Safety Thermometer information at the entrance to each of the wards we visited. This included information about falls with harm, new venous thromboembolism, catheter use with urinary tract infections, and new pressure ulcers.
- Safety Thermometer data showed that, for the surgical specialities, the rate of falls and urinary tract infections was better (lower) than the England average. However,

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the trust's quarterly report from January 2015 showed that the trust-wide target relating to falls reduction was not met. All but two of the patient records we checked included completed falls assessments. We observed a patient on the private surgical ward who was at risk of falls, but for whom there was no falls assessment or care plan.

- The prevalence of pressure ulcers was better (lower) than the England average, but was rising according to data provided by the trust. The trust's quarterly report from January 2015 showed the trust-wide target relating to avoidable hospital-acquired grade three and four pressure ulcers was not met and the surgery and cancer clinical service centre was receiving targeted support in this area. Further data from the trust showed that 68% of all serious incidents were pressure ulcers grade three (25 incidents), the majority of which were in trauma and orthopaedics (17 incidents) but these were unavoidable. The trust's quality dashboards showed pressure ulcers were a particular concern in the trust's surgery and cancer clinical service centre.
- In its integrated performance report for January 2015, the trust reported 27 patients with avoidable pressure ulcers (26 grade three pressure ulcers and one grade four) against an annual limit of 28. Four patients were reported as having an avoidable grade three pressure ulcer in January. All four were patients in the trust's surgical departments.
- Trust board minutes from January 2015 showed the trust was meeting its monthly target to assess 95% of inpatients for venous thromboembolism. However, trust reports, including data from the week ending 8 February 2015, showed the surgical clinical service centre was not meeting this monthly target. For example, the clinical service centre that includes cancer and surgery performed below target with 87.9% of patients having a venous thromboembolism assessment. Of patients undergoing surgery within the head and neck clinical service centre, 85% had venous thromboembolism assessments. Of patients having surgery within the musculoskeletal clinical service centre, 90.2% had venous thromboembolism assessments. All the patient records we checked showed venous thromboembolism assessments were completed.
- Safety Thermometer results were reviewed at board level. Plans were in place to address underperformance against targets and these were monitored by the board.

Interventions identified by the board included improving and auditing the use of skin care bundles, providing staff with access to a tissue viability nurse and increased education for staff.

- Nursing and healthcare support staff we spoke with were able to tell us how they used skin care bundles, and why and how they could access support from the tissue viability nurse.

Cleanliness, infection control and hygiene

- The ward areas and theatres we visited looked clean. Overall standards of cleanliness in theatres and in the wards we visited were good.
- Cleaning was provided by an external contractor and we observed cleaners working in the wards in the mornings and we found wards remained clean in the evenings. Cleaning schedules were displayed on the surgical wards we visited and cleaning tasks were clearly identified. Clinical equipment, such as intravenous pumps, was cleaned by nursing staff.
- Housekeeping standards and cleanliness on surgical wards were regularly audited. Audits showed high levels of compliance with performance measures.
- We saw that staff across all three areas wore clean uniforms, with arms bare below the elbow and that personal protective equipment was available for use by staff.
- Infection control arrangements in the surgical high care unit did not meet professional guidelines. There were no isolation rooms in the surgical high care unit for infectious patients. Staff told us they would put infectious patients at either end of the ward and separate them from other patients with the use of a small screen. There were two hand washing basins in the middle of the ward but none at either end or at each patient's bed. Staff treating infectious patients at either end of the ward had to walk to the middle of the ward in order to wash their hands between patients. This posed a risk of spreading infection to particularly vulnerable patients. Although the trust were managing the risk by ensuring hand hygiene gel was available at each bed space, we observed that these were not used consistently. We observed clinical waste bins were open as were several sharps bins. If the bins fell over, they would pose an infection risk to staff, visitors, or patients passing by.
- Hand hygiene gel was available at the entrance to every ward, along corridors and at the bottom of each

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patient's bed. We observed good hand hygiene practices on some wards but poor hand hygiene practices on others. There were many instances where doctors, nurses, and healthcare support workers went from one patient to another without using hand hygiene gel or washing their hands, particularly on ward E3.

- Hand hygiene audits were completed at ward level and monitored at service level. Overall, they should good compliance with hand hygiene standards although this sometimes varied by ward and by month. Staff on all the wards we visited, except ward E3, told us they received feedback about the results of infection control audits. On ward E3, staff said they were not provided with feedback about infection control issues and were not sure how to escalate concerns regarding infection control.
- Patients admitted for surgery were screened for MRSA. For patients who were planned admissions, screening for MRSA was completed before admission. Patients who had a clear MRSA screening were admitted to surgical wards for planned procedures.
- Compared to other trusts, infection rates (March 2013 to September 2014) for MRSA and *Clostridium difficile* infections were below the national average for most of the year.
- **The trust submitted hospital site specific infection data related to knee replacements to Public Health England for two quarters in 2013/14. The data showed that out of 365 procedures, there were no infections.**
- Each ward had an infection control lead who took responsibility for infection control issues on the ward and who could provide advice and support in relation to infection control.
- Patients we spoke with had no concerns about the cleanliness of the wards and told us cleaners were regularly seen on the wards.

Environment and equipment

- Staff said they were usually able to access equipment that was needed to deliver care safely to patients, although there were significant exceptions.
- Equipment was regularly checked, although the cardiac arrest call bell system in the E level theatres did not identify the location in which an emergency took place. This was because there were few identification panels within the department to show the location of an emergency. The system did not identify where an alarm

was raised; and indicator panels had mismatched room names. This was on the theatre department's risk register. Staff told us that when there was an emergency, they called other colleagues within theatre to assist. However, at the time of our visit, this issue was highlighted by staff as a continuing concern.

- Staff told us they often had difficulties getting enough pressure-relieving mattresses for patients who needed them. During our visit we found instances where patients did not have pressure-relieving mattresses even though they were assessed as being at risk of developing pressure ulcers.
- Staff also told us they had difficulty getting intravenous pumps and drip stands. They explained that when patients moved from one ward to another, they often took their intravenous pumps and drip stands with them, and it was difficult to find replacements for patients newly admitted on the wards.
- Staff on ward E3 told us they had run out of stock, including pillows, night gowns, medicines and other equipment, consistently for the last few months. They said they were sharing stock with the newly established E4 ward and that this had caused them to run out of stock almost daily. Staff told us they had raised this with the ward manager and the head of nursing for the clinical service centre but that the issue had not been addressed until a few days before our visit.
- We visited theatre suites in both D and E level theatre complexes and found they were fit for purpose. Maintenance records showed the trust reviewed the safety and suitability of its theatres. Recovery areas were well planned and there were separate recovery areas for adults and children.
- Theatre staff told us there had been concerns about reductions in readily available stocks of equipment. The trust had introduced a stock rationalisation programme to ensure appropriate stock was available in the appropriate theatres and to reduce wastage. However, the staff told us stock had been reduced as a cost saving measure but that sometimes they could not access the equipment they needed as a result.
- Resuscitation equipment checks in all areas we looked at were completed daily. Appropriate resuscitation equipment was available in all the areas we visited.

Medicines

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- Medicines were usually stored safely, although there were some exceptions. The temperature of medication fridges was monitored.
- We observed instances where staff left drugs trolleys open and unsupervised in patient bay areas. This meant patients and visitors had access to medicines that were not prescribed for them.
- In E level theatres, we found a partly used vial of controlled drugs which was disposed of in the sharps container. This is a breach of legal requirements for the disposal of controlled drugs.
- Staff on ward E3 told us they consistently ran out of medicines and often found it difficult to get medicines for the patients on the ward. They told us they shared their medicines stock with ward E4, a newly established ward. They said they had raised this concern with their ward manager but the issue had not been addressed. The trust's medicines management team said that ward E4 had been used as an escalation ward (a temporary ward to provide additional bed capacity) and, as such, was not given its own medicines stock when it opened. We were told its medicines profile was not yet established and this was why the ward ran out of medicines stock.
- The trust's medicines management team was aware of concerns raised by individual wards about ensuring adequate supplies of medicines were available at all times and was responding to these. Staff on the team told us there had been problems ensuring wards received all the medicines they needed because of the way beds were being managed. They explained that each ward was intended to have a certain profile of patients, for example, medical or surgical patients. They said, however, that demand for beds meant that patients were often placed on any available ward rather than on a ward specifically designated to meet the needs of their condition, for example, patients needing respiratory care could be put on orthopaedic wards. The medicines management team told us wards were increasingly requiring medicines they were not originally intended to need. This sometimes made it difficult to get the medicines patients needed to the right ward. Records we saw showed the medicines management team was working with wards to identify which medicines they needed and how much. Delivery receipts we saw showed additional supplies of medicines were ordered when the medicines management team was made aware of shortages.
- We found concerns on ward D1 in relation to medicines and recording of medicines in patient records. We looked at five sets of patient records on this ward including drug charts. Prescriptions were not always written correctly, for example, the number of tablets was recorded but not the strength of the tablets.
- We looked at two sets of patient records on ward G9 and found some information related to medicines was missing. In one set of notes, we found that information about a supplementary drug chart was not filled in, which meant that a nurse looking through the records might not know to look for the additional drug chart.
- Pharmacists explained that medicines reconciliation (reviewing medicines patients have brought from home) did take place but none of the drugs charts we looked at showed evidence of this. Professional practice is that one or more sources of information should be used to determine which medicines the patient has been prescribed outside the hospital and still requires while in hospital.
- Pharmacists we spoke with did not always have an adequate understanding of insulin sliding scales or where such information was recorded, for example, in an insulin chart, a fluid chart or in an administration chart.
- During our observations of drug rounds, we saw nurses did not always ensure patients took the medicines they were given. There was one instance when an elderly patient struggled to open the packaging for their tablet and the nurse had already moved on to the next patient. This put the patient at risk of not taking their required medication.
- We observed one instance when a staff nurse obtained a vial of insulin that had been opened but had no expiry date. When we asked the nurse about the procedure for dealing with opened vials without an expiry date, they were unable to tell us the procedure. When we spoke with the nurse in charge, however, they were able to describe the correct procedure, for example, an open vial of insulin without an expiry date would not be used.
- A medicines management audit conducted by the trust in March 2014 highlighted a similar issue on the surgical assessment unit (E1) and noted a need to ensure oral medications had labels indicating the date on which they were opened or an expiry date. Failure to record the opening or expiry date of part-used medicines puts patients at risk of being given medication that is not effective.

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- Medicines management on individual wards was audited by the trust and we saw a sample of audits for the wards we visited. Audits included a review of drugs charts, prescription charts, storage of medicines, administration of medicine, use of patient lockers, stock ordering, disposal of drugs and use of medical gases.
- Good practice in antibiotic prescribing includes telling patients why they are being given an antibiotic and how long it will be given for. Out of the five patient records we looked at, two patients were on antibiotics. Both prescriptions had review dates but neither of the patient records included information about why the antibiotics were given. However, patients told us the reasons for their antibiotics were explained to them.
- Staff told us that when patients having controlled drugs move from one ward to another, the trust's policy is that a nurse on the receiving ward goes to the ward the patient is leaving and, together with a nurse on this ward, administers the patient's controlled drugs before the patient is moved.
- Patients we spoke with told us they were given good explanations of their medicines and usually understood why they had been prescribed.

Records

- Most patient records were kept in paper format, although records relating to the monitoring of deteriorating patients were kept electronically. Staff in ward areas identified and monitored patients who were at risk of deterioration through portable electronic devices.
- The paper patient records we looked at were generally legible and well maintained. However, records were not always stored in a way that maintained confidentiality. We found patient records were often left unattended on desks and countertops. Documents including patient names and details of their treatment were hung up on boards at doctors' stations on many of the wards we visited. The doctors' stations were open plan desk areas situated along a corridor. These could easily be seen by patients and visitors. Unlocked and unsupervised filing cabinets of patient records were kept in the corridor on ward E3. These were easily accessible to patients and visitors.
- Five steps to safer surgery checklists (based on the WHO Surgical Safety Checklist) should be used at each stage of the surgical pathway – from when a patient is transferred to theatre until return to the ward. In the patient records we saw, safer surgery checklists were not always completed. In one set of records in E level theatres we found the safer surgery sign out documentation and patient checklist were not completed. Staff we spoke with in recovery told us they did not send incomplete documentation back to theatre for completion. An audit of patient records in the day surgery unit undertaken by the trust from November 2014 to January 2015 found safety checklists were mainly completed but in 62% of the records they checked theatre staff failed to sign off on the checks. In two set of records we found on surgical wards, safer surgery documentation was not complete. Failure to document required safety checks poses a risk that safety checks are not undertaken and, as a result, patients may be at risk of harm.
- We looked at six patient records in the recovery area for E level theatres. We found that documentation intended to alert staff to patients who were deteriorating was either missing or not complete in half of these records. We asked a staff member about this and they told us they completed the documentation in retrospect when the patient went up to a ward. This practice meant there was risk that early warning scores would be inaccurate and would therefore fail to alert staff when a patient was deteriorating.
- We looked at three sets of patient records in D level theatres and found none contained early warning tools to detect deteriorating patients. Staff we spoke with told us they did not use recognised early warning tools to determine when patients were deteriorating.
- We looked at four sets of patient records on the private surgical ward. We found good documentation and clear treatment plans by doctors. Nursing notes, however, were minimal and provided little information about the care provided to patients. For example, one set of notes for an eight-hour shift read 'pain killers given; patient fine'. There was no information about the patient's nutrition, hydration or mobility, even though the patient's condition required these aspects of care to be monitored. The same patient was at risk of falls, but no risk assessment was completed.
- In all other areas we visited, patients had clearly documented treatment plans written by doctors and nursing care plans were in place. There were records of

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care from physiotherapists, dieticians and pharmacists. The Five Steps to Safer Surgery (WHO Surgical Safety) Checklist was present and completed in most but not all of the patient records we looked at.

- Patient records on surgical wards were usually complete, although there were some exceptions. Medicines-related information was sometimes missing. Clinical notes did not always document who saw and reviewed the patient. Medical notes were not always signed by the doctor who wrote them. For example, one patient's notes indicated that someone had asked for the patient to have a second blood transfusion but there was no record of who made this request.
- Staff told us risk assessments were completed for each patient when they were admitted onto a ward and we saw evidence of this. Falls risk assessments were undertaken to alert staff to potential falls risks and we saw examples of these in almost all the records we saw. There was a skin care bundle for patients who were identified as at risk of developing a pressure ulcer, which provided prompts on the actions to be taken to manage the risks.
- In two of the patient records we looked at on ward E2 we found weekend handover documents that were completed to a high standard.

Safeguarding

- Training records sent to us by the trust for its surgery and cancer clinical service centre showed a high take up of safeguarding training by nursing staff. Nursing staff told us they had safeguarding training and were aware of safeguarding procedures and protocols. They were able to describe situations where they would raise a safeguarding concern.
- Completion of safeguarding training by surgical and dental staff varied considerably by speciality even though safeguarding training was identified as mandatory. Data for surgical staff in colorectal surgery, upper GI surgery and theatres showed a high level of completion of safeguarding training, meeting or exceeding the trust's target of 85%. Completion of safeguarding training in breast surgery and orthopaedics was low and did not meet the trust's target.

- Nurses who had raised safeguarding concerns explained how they had done so and how such concerns were investigated and addressed. They told us safeguarding concerns were documented on the trust's electronic incident management system.
- Staff on all the wards we visited could identify a safeguarding lead to whom they could go for advice and support.
- Staff told us safeguarding training was tailored to meet the specific needs of different wards, for example, safeguarding training for theatre staff was tailored to the needs of theatre staff and training for ward staff was matched to the needs of staff on the wards.

Mandatory training

- Training records sent to us by the trust for its surgery and cancer clinical service centre showed a high take up of mandatory training by nursing staff. Nurses and healthcare support workers we spoke with told us they had completed their mandatory training and could describe what was included in the training. Theatre and ward managers told us they monitored attendance at mandatory training and their staff were up to date. Staff told us that because of staff shortages in some areas, they sometimes had to cancel their attendance on training days to meet staffing levels on the wards.
- Completion of mandatory training by surgical and dental staff varied considerably by speciality. Records showed that almost none of the surgical specialities were meeting the trust's target of 85% completion of all statutory and mandatory training. Mandatory training included complaints handling, dementia awareness, infection control, safeguarding adults, safeguarding children, information management and medicines management. Surgical staff in general surgery and orthopaedics showed the lowest take up of mandatory training against all required courses. Fire safety training was often the least well-attended training by surgical staff across all surgical specialities.
- There was an induction programme for all new staff. New staff were complimentary about the trust's induction programme and felt well supported when they started working in the trust. They were able to describe induction arrangements and what was included in their induction.
- Staff who were on extended periods of leave, for example as a result of sickness or maternity, were not always given an induction when they returned to work.

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Staff who had returned from a period of extended leave told us the lack of induction was not a concern for them because their colleagues and managers were usually very supportive.

Assessing and responding to patient risk

- Staff used a surgical safety checklist based on the internationally recognised WHO Surgical Safety Checklist to ensure required pre- and post-operative safety checks were undertaken. The trust conducted an observational audit of compliance with its WHO Surgical Safety Checklist in January 2015 and found overall compliance with required standards was high at 96.3%. It did, however, identify some areas in documentation and practice that needed to be improved, and that 8% of records had missing signatures. During our visit, we observed staff undertake required safety checks including a team brief and completion of the trust's surgical checklist.
- Pre-operative assessments were carried out before surgery and patients we spoke with were complimentary about their pre-operative assessments. However, staff undertaking pre-operative assessments were not aware of agreed indicators for determining when day surgery might be inappropriate for a particular patient. Although protocols and flowcharts were available to staff, staff were unaware of trust protocols for using body mass index in order to assess whether surgery continued to be appropriate for a given patient. Staff told us there were no standardised trust protocols for assessing whether a patient needed an anaesthetic review. They told us they used their professional judgement to determine when such a review was required. There were also no standardised protocols to support staff in deciding when to refer patients for an electrocardiogram.
- Risks in relation to infection control were assessed in relation to performing cataract surgery in B level operating theatres 1 and 2. The design of the theatres resulted in trolleys that had been used during theatre being taken through clean areas of the theatre in order to remove them from surgery. This posed a risk that the clean areas could become contaminated and become a source of potential infection. The trust had protocols to ensure that the clean and dirty streams did not crossover. We observed however, that the protocols for the flow from clean to dirty were not always followed. The trust were currently looking to redesign the flow patterns to allow the dirty instruments to be stored and collected from the theatre area once the procedures were completed and patients had left the intra-operative areas. Theatres 1 and 2 shared one set of doors through which patients were brought into and taken out of surgery. We observed patients in one theatre being taken through the doors when their surgery was finished while patients in the other theatre were still being operated on. Both operative areas were serviced by a single air handling unit which had been commissioned to meet the required design standards and not pose a risk of contaminated air even when the doors were opened to allow a patient to exit. The infection rates after cataract surgery were within the national average.
- Managers told us that neither of these practices was formally risk assessed. However, infection rates and patient outcomes were monitored by the eye department's clinical-effectiveness committee. The trust's annual audit of cataract procedures, using data from September 2013 to September 2014, showed low rates of infection. This suggested the risk of patients developing an eye infection from these practices was minimal.
- The surgical wards used a portable electronic device with early warning software for assessing acutely ill patients. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of them. We saw examples of where portable devices were used to identify deteriorating patients.
- Nursing handovers occurred three times a day and we observed one of them. Staff on many of the wards we visited told us staffing for the shift was discussed as well as any high-risk patients or potential issues. However, when we observed a nursing handover on ward E3, there was little discussion of patients' needs. High risk patients were not highlighted, and staffing was not discussed.
- We observed a medical handover that was led by a consultant and was attended by nine junior doctors and four nurses. The team reviewed a large number of patients with a brief presentation and a management plan for each, and more time spent reviewing difficult cases. The previous night's admissions were discussed along with updates on ward activities. Concerns were discussed, for example, there were concerns about long waiting times for CT scans that then delayed treatment.

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- We observed a multidisciplinary team ward round on the inpatient renal transplant ward. Attendees included a consultant nephrologist, a transplant surgeon, a transplant specialist nurse and the nurse in charge. We saw clear communication between members of the team and discussion about each patient's care and treatment. There was good hand hygiene practice in between reviews of each patient. Patients were involved in their reviews and were supported to achieve their goals. Complex information was presented in lay person's terms and patients were encouraged to ask questions.
- Staff across surgical sub-specialities told us there were regular multidisciplinary team meetings to discuss and plan individual patients' care. We saw weekly records of these meetings and they showed patients' care and treatment was reviewed.

Nursing staffing

- Staff on every ward we visited told us they were short staffed and sometimes struggled to maintain recommended staffing levels. We looked at staff rotas on all the wards we visited and found they were repeatedly and consistently short staffed.
- For example, on ward E3, which accommodated patients who were acutely ill and required high levels of nursing care, nurse to patient ratios were sometimes 1:12. On one of our visits to the ward, we found there were two nurses, supported by a ward sister, looking after 32 patients. We looked at a sample of staff rotas on ward E3 for the period of 12 January 2015 to 11 February 2015. We found early and late shifts were short at least one nurse on each of the days we looked at. Night shifts were almost always short one nurse, having two out of the three nurses which were allocated to the shift. The rotas we looked at showed that, of the nights we checked, one of the two nurses on duty each night was an agency nurse. The level of nurse staffing on this ward fell below recommended staffing levels. Guidance from the National Institute for Health and Care Excellence (NICE) recommends a nurse to patient ratio of 1:8 during the day and the Royal College of Nursing recommends levels of 1:10 at night. Staffing on ward E3 was deemed "unsafe" by staff and posed a risk that patients might not get the care and treatment they needed.
- Staff on the surgical assessment unit (E1) told us they usually had their full complement of nursing and support staff during the day and evening shifts, but that the number of night staff on duty was insufficient for the volume of patients coming onto the ward at night. They told us that the unit was as busy during the night as it was during the day, but that there were fewer nursing staff and no ward clerk or nurse practitioners to support the ward. They said this made it difficult to always provide consistent standards of care to all patients through the night.
- Staff told us they managed staffing shortages by using agency staff, if they could get them, and by moving staff from better staffed wards to less well staffed wards.
- Staff expressed concerns that some agency staff were unable to give intravenous medications. They said this often delayed care for patients. For example, staff on one ward told us of one night where one nurse was on shift supported by an agency nurse, together caring for 32 patients. Because the agency nurse could not administer intravenous medication and two nurses were required to administer this, the nurse had to search the hospital for a staff nurse to assist her. Staff told us some patients were not given their medicines that night until after midnight even though they should have had them earlier.
- Staff expressed concerns that moving nursing staff from one ward to another to cover staff shortages resulted in less continuity of care for patients. Nurses were also concerned that the specialist expertise they had developed in certain areas was not being used when they were moved to another ward. Consultants told us they felt nursing expertise was not used to its best advantage when nurses with specialist skills on specific wards were asked to care for patients who were outliers on specialist wards. Ward managers expressed concerns that losing nursing staff to provide cover for other wards sometimes made it difficult to maintain an adequate skill mix on their own ward.
- Staff on ward E3 said they had raised nurse staffing levels as a concern with the ward manager and reported them as incidents, but their concerns had not been addressed. We found the nurse in charge of each shift, in addition to their own duties, was acting as the ward manager and, at times, caring for a list of patients.
- Patients on ward E3 were at high risk of developing pressure ulcers because there were not enough staff to care for them. During our visit, there were nine patients identified as having a grade two or three pressure ulcer and another ten who were identified as being at risk. Staff

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told us this was because they did not have time to turn patients as frequently as required and because they did not have as many pressure-relieving mattresses as they needed.

- We observed instances where patients were not appropriately cared for, for example, we saw one patient whose urinary bag had been leaking and the front of their hospital gown was wet. The patient's relative raised this with a healthcare support worker who replied that the nurses were too busy to address the issue. We also observed instances on ward E3 where equipment required attention, for example intravenous pumps and pressure-relieving mattresses, and staff were unable to respond to the alarms indicating attention was required.
- Patients we spoke with on both these wards commented that it was a very busy ward and staff often seemed rushed. While most of these patients felt the care they received was adequate, there were several patients (and relatives) who told us it sometimes took a long time for staff to answer their call bells. We spoke to the family of a patient who raised concerns about lack of mouth care, infrequent repositioning to prevent pressure ulcers, the oxygen mask repeatedly being found on the floor and the stoma bag not being changed.

Surgical staffing

- There was seven-day consultant cover across the service and patient records showed patients were seen by consultants during the weekend. However, there were vacancies at consultant level, with a need for further anaesthetic staff. The trust was recruiting for these.
- Trust management told us there had been a shortage of urology surgeons earlier in the year, which had resulted in a backlog of complex and robotic surgery. By December 2014, additional urology surgeons had been recruited and were in post. Data from the trust's integrated performance report in December 2014 showed improvements in performance against targets in urology.
- Junior doctors told us that there were adequate numbers of junior staff on the wards during weekdays but that there was often insufficient junior medical staff presence at night and at weekends. For example, they said that during weekends there could be one junior doctor (FY1) to cover two wards totalling 60+ patients.

However, there was consultant cover and a specialist registrar on call. While junior doctors did not feel this was unsafe, they felt overworked at weekends and were unable to take breaks.

- Junior doctors said work pressure was increased because patients were frequently moved from one ward to another and they had trouble locating them. While consultants had access to an IT database that could help them find patients in the hospital. The trust identified that junior doctors had access to the IT database if they request this. However, the junior doctors we spoke with were unaware of this and told us they did not have access to this system and so spent considerable time trying to find the patients they were supposed to be looking after. This arrangement posed a risk that patients requiring medical review or treatment would not receive it because they could not be located.
- Junior doctors said they were also under pressure on weekends to get prescriptions to the pharmacy before 2pm for patients who were ready for discharge. Junior doctors felt this was difficult to do on top of a ward round that could include up to 120 patients, many of whom they had difficulties locating because of numerous patient transfers between wards.
- Nursing staff told us there were usually enough junior doctors during the weekday and at night, but that there was inadequate medical cover during weekends. They said this sometimes resulted in delays to patient care, for example, giving patients intravenous medicines.
- Staff on the surgical assessment unit (E1) told us they could not always access a registrar or consultant on the ward to help with patient discharges. They said sometimes patient discharges were delayed because ward staff could not locate medical staff who could review scans or blood tests.
- Some junior doctors told us that on weekends they often stayed at least an hour after their shift because handovers ran over. However, they said they did not mind because it was good experience and they felt they had good teaching from more senior doctors. They said that the consultants were contactable by phone if they required advice or support and they felt well supported by their senior colleagues.
- Staff from the anaesthetics team told us they rarely had an opportunity to take breaks between patients because there were insufficient staff. Minutes from the service's February 2015 governance and quality committee identified a need to recruit to anaesthetics.

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- There was 24-hour consultant on-call cover for the surgical wards, seven days a week. Staff told us there were sometimes difficulties in getting support from a consultant, especially when consultants were in theatre. They said this sometimes caused delays in managing patient care. Outside of theatre, however, they said consultants were easily contactable and responsive.
- Junior doctors were part of the 'hospital at night team' that stayed on site for emergencies. We were told they could contact senior staff for support if required.

Major incident awareness and training

- There was a trust major incident plan and staff were able to tell us their role in it. They said they had major incident exercises to practice and ensure their familiarity with the plan.
- Emergency plans and evacuation procedures were in place.
- Staff told us about the hospital's business continuity plans and said these had been used to manage demand for services over the winter.

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.

Clinical guidelines were available for use and took into account guidance from the National Institute for Health and Care Excellence (NICE). However, a number of standard operating procedures in theatre were out of date. Patient outcomes against a number of indicators were better than the England national average. Clinical audit was used to monitor compliance with evidence-based national guidelines and best practice, and to ensure clinical practice improved. Information on outcomes was shared within individual surgical specialities and relevant performance data was shared with ward staff.

Patients' pain levels were assessed regularly and patients told us they received adequate pain relief. Patients' nutrition and hydration status was assessed and recorded

on all the wards we visited, except the private surgical wing. Staff described good access to training and teaching and annual appraisal, although there was no system of clinical supervision for nurses.

When patients were confused or there was a question about their capacity to consent, mental capacity assessments were undertaken by surgical staff to determine whether they could make decisions relating to their care and treatment. However, ward staff were not always clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Multidisciplinary working was evident to support and coordinate patient care. There were seven-day consultant-led services.

Evidence-based care and treatment

- Surgical services adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients.
- Staff told us NICE guidelines were discussed at clinical governance meetings and we saw this in the minutes and records of these meetings.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcomes and Death recommendations.
- The NHS Productive Operating Theatre guidelines were in use and we observed examples of good practice in relation to them. For example, there were photographs of different pieces of equipment hung up on the wall, identifying the name and expected use of the equipment.
- National guidelines and the enhanced recovery programme were used, where relevant.
- However, the risk register for theatres indicated that many standard operating procedures needed to be reviewed and that there was no system for alerting senior managers about expired standard operating procedures. Minutes from theatre governance meetings in June 2014 and February 2015 showed standard operating procedures continued to be under review and significant work was still required to bring them up to date.
- Regular clinical governance meetings were held to discuss changes to guidance and the impact of changes on services.

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- The trust participated in relevant national clinical audits for surgical procedures. There was also evidence of a trust-wide audit and ward-based audit programmes that were used to monitor the quality of care.
- Results of audits were disseminated and this was noted in the clinical governance meeting minutes we saw. Ward staff told us they received feedback from audits done of their wards. Theatre staff told us of an audit that highlighted they were not always writing down their role designation. This issue was raised at a team meeting and was monitored. They also described a pregnancy audit that identified staff were not adequately recording information related to potential pregnancy. Staff told us they were reminded to record this information at team meetings and were provided with further training in doing so.

Pain relief

- In the CQC National Inpatient Survey published in April 2014, which included 443 respondents, the trust scored 7.9/10 for pain management. The trust scored 'about the same' in this area as similar trusts nationally.
- Patients were assessed pre-operatively for post-operative pain relief and patients' preferences were discussed.
- The trust used a pain management system that was embedded in portable electronic devices which they used to monitor patients. The system used a 0–3 scoring system, with 0 being no pain and 3 being severe pain.
- A system of assessing pain called the Abbey Pain Scale was used to assess pain in patients who could not communicate well. Staff told us they usually used this scale with patients who have a learning disability and who are unable to verbalise how much pain relief they require.
- Patient records showed patients were given pain relief and were usually asked later whether the pain relief was sufficient to control their pain. There were, however, some exceptions to this in the records we saw, one of which was on the private surgical ward. There was a patient on this ward who persistently complained of pain but there was no evidence in the patient's records that the effectiveness of the patient's pain relief had been reviewed.
- Most patients we spoke with reported that their pain was well-controlled and staff provided them with pain relief promptly when requested. We found one instance where a patient was prescribed morphine by their own GP before going into hospital. The patient told us this was to manage their pain. However, the patient's family told us hospital staff did not administer the morphine because the dosage required was not recorded by the GP and hospital staff had not had an opportunity to clarify the dosage. This was the appropriate action to ensure patient safety. However, the medical review was not timely. Staff had given the patient paracetamol in the interim.
- There was a dedicated pain team that could be accessed for support in controlling patients' pain. Staff told us the pain team was easily accessible and could be contacted for support when required.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the wards we visited, except the private surgical wing. The patient records we looked at on the private surgical wing showed that one patient who required an assessment of nutrition and hydration did not have one.
- The Malnutrition Universal Screening Tool was used to identify patients who were at risk of malnutrition. Patients identified as being at risk were referred to a dietician and we saw care plans were in place to address special requirements. We observed that fluid balance charts were used appropriately to monitor patients' hydration status.
- We observed that patients usually had access to drinks that were within their reach, although there were some exceptions. On ward E3, we observed some patients did not have water to drink and had to ask for water. This was not always provided promptly.
- The patients told us they were given meal choices and most rated the quality of food as adequate.
- The trust operated a 'red tray' system to identify patients who needed support to eat and drink, and we saw this in use. Patients who needed assistance were also identified to staff through the use of a red tray symbol on the patient information board above each bed.
- We spoke with an NHS patient on the private surgical ward who had surgery the day before our visit to the ward. When we spoke with the patient, it was 11am and the patient had not been given any food to eat since surgery. The patient had not been given a reason for this. When we checked the patient's records, there was no documented reason for the lack of food.

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Patient outcomes

- The hospital's overall mortality rates were lower than expected and there were no mortality outliers (outside the expected range) for this service.
- 89.5% of patients with a hip fracture received surgery within 48 hours; this was better than (above) the England average, as was the trust's score for patients receiving a pre-operative assessment by a geriatrician. According to the survey, the percentage of hip fracture patients developing pressure ulcers post-surgery was better than the national average.
- Data showed the length of stay of patients with hip fracture was lower (better) than the England average.
- The service took part in national audits, for example, the elective surgery Patient Reported Outcome Measures (PROM) programme, National Hip Fracture Database and National Joint Registry.
- PROM scores for improvements in general health and condition-specific indicators after procedures were the same as or slightly better than the England average.
- Results from the National Emergency Laparotomy Audit 2014 were varied and identified a number of required policies and procedures were not yet in place.
- An audit of cataract outcomes and complications for procedures performed from September 2013 to September 2014 showed better outcomes in relation to cataracts surgery than the national average (using the cataract national dataset). Infection rates after cataract surgery were within the national average.
- The trust had overall good results in both the National Bowel Cancer Audit and National Lung Cancer Audit. Bowel cancer audit results showed that the number of patients seen by a clinical nurse specialist were better than the national average.
- Standardised relative risk readmissions for non-elective surgery at Queen Alexandra Hospital compared favourably with national comparators. However, data showed urology elective readmissions were significantly higher than the national average.

Competent staff

- Staff said there was access to regular training and support, although they were not always able to attend training because of staffing pressures.
- Junior doctors told us there was good access to clinical supervisors within the trust. They also said there was good support and teaching from senior house officers.

- Senior house officers were pleased with the teaching provided by consultants.
- We observed examples of good teaching in theatre E2 during colorectal surgery. In D level theatres we observed a consultant teaching a junior doctor about anaesthetics.
- Nursing staff told us they had annual appraisals, but did not have supervision. Ward managers we spoke with could not describe the process of supervision or what it consisted of. The exception were Ministry of Defence staff, who told us they had supervision through the Ministry of Defence.
- The trust had a procedure it was following to achieve revalidation for consultant surgical staff.
- In the General Medical Council National Training Scheme Survey 2014, the trainee doctors within surgical specialities generally rated induction, regional and local training, supervision, study leave, handover arrangements, and their overall experiences at the trust as 'similar to other trusts' or better. There were some exceptions. Trainees in urology rated many aspects of their training as adequate but their overall experience was rated as below average. In general surgery, trainees rated their training as being similar to other trusts but raised concerns about workload pressures.

Multidisciplinary working

- We saw evidence of multidisciplinary team working on all the surgical wards we visited.
- Daily ward rounds were undertaken seven days a week on all surgical wards, except for the surgical high care unit where patients were seen twice a day. Surgical and nursing staff were involved in these rounds.
- We observed one ward round on the renal transplant ward (G9). The ward round was attended by a consultant nephrologist, a transplant surgeon, a transplant specialist nurse and the nurse in charge.
- Patient records we looked at showed care and treatment was provided by a variety of healthcare professionals including nurses, doctors, pharmacists, physiotherapists, dieticians, social workers and others.
- Patient records showed patients were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.
- There was dedicated anaesthetic support on the surgical high care unit.

Seven-day services

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- An area prioritised in the trust's clinical service strategy was access to care 24 hours a day, seven days a week (called 24/7 care). In surgery, we saw the trust had made significant progress against this objective. For example, general surgery had implemented a 'surgeon of the week' programme to better manage emergency surgeries and to ensure 24/7 consultant on-call cover.
- Staff told us there were consultant-led seven-day services. Patient records we looked at showed surgical patients on surgical wards were reviewed during the week and at weekends by consultants.
- Surgical staff expressed concerns that medical patients on surgical wards were not seen by a consultant on weekends unless there was an identified need, or a review was requested.
- Staff told us access to medical advice at night came from the hospital at-night team, although junior doctors could contact consultants if they needed to. Staff told us the hospital at-night team provided advice and assistance when needed.
- Physiotherapy was available seven days a week for orthopaedic patients. A limited physiotherapy services was available on weekends for patients on non orthopaedic wards.
- Radiology on-call services were available at all times, including weekends. Staff could access CT scans, MRIs, ultrasounds and emergency plain films. Services were consultant-led.
- Interventional radiology on-call was available only during the weekday from 9am to 5pm. Out of hours cover was provided by University Hospital Southampton NHS Foundation Trust. Staff told us patients needing interventional radiology out of hours would be transferred to Southampton by ambulance.
- The pharmacy department was open seven days a week, but with limited hours on weekends. There were pharmacists on-call out of hours to provide advice to staff on duty.

Access to information

- Patient records were stored as hard copies and more limited information was kept on a handheld portable device that staff used to monitor whether a patient was at risk of deteriorating.

- Staff told us they usually had good access to patient-related information and records when required. 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 when patients were transferred between wards they received a handover.
- Electronic discharge summaries for patients were sent to GPs, but they were not always sent immediately when the patient was discharged from hospital. This posed a risk that patients might not receive the care they need when they went home or were discharged into the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. When patients did not have capacity to consent, formal best interest decisions were taken in deciding the treatment and care patients required.
- When patients were confused or there was a question about their capacity to consent, mental capacity assessments were undertaken by surgical staff to determine whether they could make decisions relating to their care and treatment. We found one exception to this on ward E3, where a confused patient was not assessed for capacity and where staff did not know how to escalate this.
- Ward staff were not clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. They were unable to summarise the key points of the MCA and the implications of the MCA on their work.
- Some of the staff we spoke with told us they had training in the MCA as part of their induction, but they said they had no further training in the MCA since then.
- Managers told us there were plans to implement MCA awareness training as well as awareness training about the role of the independent mental capacity advocates.

Are surgery services caring?

Requires improvement



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

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We rated caring as requires improvement.

Patients were not always treated with compassion, dignity or respect. On ward E2, we observed a ward round in which confidential discussions about individual patients could easily be overheard by other patients and visitors. Patients on the ward were able to tell us about the care and treatment being given to the patients around them. We saw several examples where patient dignity was not maintained on ward E3. We observed one patient whose urinary bag was leaking and when their family raised this with a member of staff, they were told the nurses were too busy to help. We observed a patient in a four-bedded bay area who was trying to vacate a bed so that the bedding could be changed. The patient seemed to be in considerable pain and started to cry. The two nurses who were changing the bed opposite did not respond or assist the patient. We observed another nurse who was assisting another patient in the bay area comfort the patient and draw the curtains around their bed. No comfort rounds were undertaken on ward E3. Staff told us this was because of nursing shortages on the ward. Staff told us comfort rounds were supposed to be undertaken by ward staff and required staff to visit every patient and ask them whether they would like something to drink, or whether they would like to be repositioned or use the bathroom.

We observed that patients on all other surgical wards did receive patient centred care and many of the patients we spoke with felt staff treated them with compassion and empathy. They generally felt well-cared for and told us staff were responsive to their needs. Although patients and relatives across all the wards we visited told us that where their needs were not always met, this seemed to be caused by lack of available staff. Some patients also commented that some groups of nursing and healthcare support staff were more compassionate than others. Many nursing staff from other countries were highlighted as being more compassionate. The trust had a training programme to ensure that good practice was being shared with all staff.

Most of the patients and relatives we spoke with said they felt involved in their care. They said they were given opportunities to speak with the consultant looking after them and to ask questions. Staff in all the areas we visited were able to describe specific arrangements for involving patients with special needs and their families in planning and providing care and treatment.

Clinical nurse specialists were employed throughout the trust to provide support and advice to patients undergoing various types of procedures. We saw and spoke with a number of clinical nurse specialists on the surgical wards we visited. Almost all the patients we spoke with praised staff for their responsiveness, friendliness and emotional support.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. For example, we observed staff closing curtains when providing personal care, interacting patiently and respectfully with very confused patients, and involving patients in choices about their medication. We saw physiotherapists patiently supporting and encouraging patients in their rehabilitation exercises. The ward round we observed on the renal transplant unit showed particularly compassionate care for patients. Patients were given time to ask staff questions and to have an input into their own care. Staff were responsive to individual patient needs, physical and emotional.
- We did, however, observe some examples where patients were not treated compassionately and their dignity was not always maintained. On ward E2, we observed a ward round in which confidential discussions about individual patients could easily be overheard by other patients and visitors. Patients on the ward were able to tell us about the care and treatment being given to the patients around them.
- On ward E3, we saw several examples where patient dignity was not maintained. We observed one patient whose urinary bag was leaking and when their family raised this with a member of staff, they were told the nurses were too busy to help. We observed a patient in a four-bedded bay area who was trying to vacate a bed so that the bedding could be changed. The patient seemed to be in considerable pain and started to cry. The two nurses who were changing the bed opposite did not respond or assist the patient. We observed another nurse who was assisting another patient in the bay area comfort the patient and draw the curtains around their bed.
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undertaken by ward staff and required staff to visit every patient and ask them whether they would like something to drink, or whether they would like to be repositioned or use the bathroom.

- Data from the NHS Friends and Family Test from January to July 2014 showed patients were generally satisfied with the care they received on surgical wards. Results for these wards were consistently above (better than) the England average. The results of the Friends and Family Test were displayed on all the wards we visited and showed results for the trust's surgical wards continued to be above the England average. The results of the Friends and Family test for ward E3 varied, but was most often below the England average.
- The CQC Adult Inpatient Survey (2013) showed the trust performed about the same as other trusts in all areas, including operations and procedures.
- The Cancer Patient Experience Survey (2013) showed that with regards to surgery, the trust performed as well as other trusts with reference to patients being given written information about operations, and receiving clear information about what patients could and could not do post-discharge from hospital. Areas where the trust performed worse than other trusts concerned staff giving conflicting information and GPs being given enough information about patients' condition and treatment.
- We observed a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity.
- We did not observe any breaches of single-sex accommodation. Staff told us a breach of single-sex accommodation was rare and would be reported as an incident.
- Many of the patients we spoke with felt staff treated them with compassion and empathy. They generally felt well cared for and told us staff were responsive to their needs. Patients and relatives across all the wards we visited told us that where their needs were not met, this seemed to be caused by lack of available staff.
- Some patients also commented that some groups of nursing and healthcare support staff were more compassionate than others. Many nursing staff from other countries were highlighted as being more compassionate. Trust managers were aware of these concerns and a training programme had been implemented in response.

Understanding and involvement of patients and those close to them

- Patients told us they were pleased with their pre-operative assessment. They said they were given sufficient verbal and written information about their procedures and their questions were satisfactorily answered.
- Most of the patients and relatives we spoke with said they felt involved in their care. They said they were given opportunities to speak with the consultant looking after them and to ask questions.
- Staff in all the areas we visited were able to describe specific arrangements for involving patients with special needs and their families in planning and providing care and treatment.
- We observed what staff on the surgical assessment unit (E1) called a transfer board. It included the names of patients who had been transferred out of E1 to another ward and the name of the ward to which the patient had been transferred. Staff told us this was so that they could help family members locate relatives who had been admitted and moved to another ward.
- On each of the wards we visited there was a poster illustrating and explaining the different staff uniforms and staff designations.

Emotional support

- Clinical nurse specialists were employed throughout the trust to provide support and advice to patients undergoing various types of procedures. We saw and spoke with a number of clinical nurse specialists on the surgical wards we visited.
- Almost all the patients we spoke with praised staff for their responsiveness, friendliness and emotional support.

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.

The high demand for beds across the trust meant that there were sometimes not enough beds for the number of

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patients requiring them. Surgical and medical patients with different levels of illness and risk were mixed together on all the surgical wards we visited. Patients were not always put on wards that were best suited to meeting their needs for specialist treatment and care. Patients were often moved multiple times at any time of day or night for non-clinical reasons. This included patients who were easily confused and who had dementia. Surgical staff told us they sometimes had difficulties finding patients because of the number of times patients were moved from one ward to another.

The service was meeting the national referral-to-treatment target of 18 weeks for patients on the waiting list but was not meeting the target for patients being admitted for surgery. Capacity issues within the hospital resulted in elective procedures being cancelled. Some patients told us their operations had been cancelled several times, although most did go on to have their surgery within 28 days. The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target. The trust was not meeting the 62-day referral-to-treatment target overall. The target was not being met in head and neck, lower GI and urology surgical specialties.

Electronic discharge summaries were not always sent out to patients' GPs within 48 hours of discharge. The risk is that GPs will not be informed of the care and treatment patients require in the community and patients may not get the community-based care they require.

There was a specialist learning disability nurse who provided advice and support to staff in meeting the needs of patients with a learning disability. An interpreting service was available for people whose first language was not English and the service was used. Information from complaints was reviewed and acted on, although patients told us they were not given information about how to make a complaint.

Service planning and delivery to meet the needs of local people

- A nurse coordinator was based on the surgical assessment unit (E1) during the day to take referrals from the emergency department (ED) and from GP practices in the community. There was also an ambulatory bay where patients who did not require an overnight stay were referred for assessment.

- Nurse practitioners, form part of the established workforce within the surgical assessment unit during the day assessed patients and prescribed fluids and medication. Staff told us the nurse practitioners were supernumerary to the nursing staff numbers and were introduced in response to clinical need.
- There were two emergency ear, nose and throat (ENT) treatment rooms staffed by specialist registrars so that non-critical ENT patients coming from the ED could be seen quickly and did not have to wait for long in the ED.
- Managers from the trust's surgery and cancer clinical service centre described a number of changes the trust had made in response to increased demand for services and required improvements to the 'patient experience'.
- For example, managers from the cancer and surgery clinical service centre explained their plans to reorganise rotas in response to the high demand for emergency surgeries. They told us about 'one stop' services that were developed so patients could access a number of services at one time. They also described the work of the colorectal clinical nurse specialist team in engaging with a focus group of patients to improve services.
- There were plans to develop the renal transplant service in response to the increasing need for renal services, and to make services for renal transplant patients more geographically accessible.

Access and flow

- Bed occupancy of the trust was significantly higher than the national average. 85% occupancy level is the accepted level at which bed occupancy can start to affect the quality of care afforded to patients and the systematic running of a hospital. The trust's bed occupancy rate of 92.2% between April and June 2014 was higher than the England average of 88%. Staff told us that unusually high demand for ED services and a high volume of emergency surgery had put considerable pressure on bed availability.
- The trust was meeting the target of having 92% of patients on a list waiting to start treatment (incomplete pathway) in all specialities except urology and general surgery. The trust's integrated performance report showed the failure to meet the target in urology was planned.
- Overall, the trust was not meeting the referral-to-treatment (RTT) target of 90% of patients starting treatment within 18 weeks (admitted pathway,

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April 2014 – January 2015), although this was a planned fail in agreement with Commissioners to address patients on the waiting list. Targets were not achieved in general surgery, trauma and orthopaedics, urology and ENT. In relation to urology, the trust attributed delays to limited staffing capacity, which had led to the cancellation of over 200 elective surgeries and a reduction in the number of elective patients admitted.

- Trust board minutes from October 2014 showed the trust had failed to meet the RTT target after July 2014. According to the trust's integrated performance report, the trust was meeting RTT targets by December 2014. The trust had planned and agreed with NHS England to fail the RTT during August to November 2014 so that it could address the backlog of patients on the waiting list.
- From April 2014 to January 2015, the trust met the 31-day cancer waiting time diagnosis-to-treatment target. The trust had met the 62-day waiting time target from referral to treatment up to December 2014. This target was not met in January to March 2015 in head and neck, lower GI and urology surgical specialties.
- Staff on the surgical assessment unit (E1) told us that patients were supposed to stay on the ward for between 24 and 48 hours but were often staying on the ward much longer because there were no available beds for them. During our visit to the unit, there were four patients who had been there for more than 48 hours and one patient who had been there for ten days. Staff on the unit also told us patients frequently waited to be admitted in the day area because there were no beds for them.
- Recovery staff told us surgical patients were often kept in recovery for long hours and occasionally overnight because there were no beds for them on the hospital wards. Ward staff told us that sometimes patients were admitted to their ward pre-operatively and were designated a bed but that by the time the patient's operation was finished, the bed was taken by another patient. We found patients were sometimes discharged directly from the surgical high care unit because, although there was no clinical reason for them to be on the unit, there were no available ward beds.
- We spoke with patients who told us their operations had been cancelled several times, although most did go on to have their surgery within 28 days. Data sent to us by the trust showed an overall increase in the number of cancelled operations from February 2014 to December 2014, although numbers of cancellations fell during two

months in that period. The trust's integrated performance report from January 2015 showed there were eight patients in January whose surgery was cancelled for non-clinical reasons and who were not given an alternative date for surgery within the 28-day national target. Seven of these were cancelled because there were no available ward beds and one because there was no intensive therapy unit/high dependency unit bed. Information from the ENT mortality and morbidity meetings held in November and December 2014 showed cancellations for this speciality were due mainly to a lack of available beds.

- Managers told us that emergency surgery took priority over elective procedures and that sometimes this meant having to cancel elective operations. Procedures were often cancelled because of lack of surgical staff or lack of available inpatient beds. Managers told us that medical outliers (medical patients who should be on medical wards) used approximately 20% of surgical beds on a daily basis. Managers recognised the risks in cancelling elective operations and described their plans to improve surgical services. This included recruitment of surgeons and opening up additional beds on previously disused wards that were now refurbished.
- We found bed management across the hospital's surgical wards needed to improve. Staff told us they did not feel supported by the bed management team. Patients were not placed on the most appropriate ward for their needs. Elective and emergency patients were mixed together on wards. Medical and surgical patients were often mixed on surgical wards. Trauma or respiratory patients were mixed with patients who were recovering from orthopaedic surgery. Patients receiving end of life care were mixed with surgical patients on a general surgery ward.
- Staff and patients in all the wards we visited told us patients were moved from one ward to another repeatedly and at any time of day or night regardless of their clinical condition. Doctors told us they often could not find patients because patients were not where they were expected to be and were moved frequently.
- We spoke with patients who told us they were moved between wards in the middle of the night and they had observed other patients being moved at night. Some patients said they were moved at least three times

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within a two day period. Patients said they were not told why they were moved and expressed frustration at being moved, particularly at night. They said moving wards frequently was confusing and disorientating.

- Staff confirmed that patients were often moved frequently in short spaces of time. Staff told us that although the trust policy was not to transfer patients after 8pm, patients were frequently moved after that time. The trust did not have performance data on patient moves specified for each clinical service centre. The trust's integrated performance report from January 2015 showed that in January there was a total of 228 patient moves which took place between 11pm and 6:59 am. Surgical patients were a proportion of this total. The report noted the number of patient moves across the trust had increased by 37 moves since the previous month. This was attributed to capacity pressures.
- Discharge planning was variable across the wards we visited. Some of the patient records we saw showed discharge planning which started at admission and others showed little evidence of discharge planning. Most of the patients we spoke with said they had been involved in planning their discharge arrangements and felt they understood their discharge plans.
- Staff told us there were often problems in discharging patients but that the issue had been recognised by the trust and discharge arrangements were improving. For example, staff told us discharges were sometimes caused by delays in getting 'to take out' prescriptions (TTOs) which need to be written by doctors. Delays had been alleviated by sending patients to a discharge lounge where they could wait for their prescription instead of waiting in a bed. We spoke with one patient who was waiting to be discharged. They told us they were discharged at 8:30am and at 10.30am were still waiting for their TTO.
- National data showed the main causes of delayed transfers of care at this trust (which could prevent a patient from being discharged) included waiting for nursing home places, waiting for social care arrangements, and patient / family choice. This information reflected what staff told us during our visit.
- Electronic discharge summaries were not always sent out to patients' GPs within 48 hours of discharge. The risk is that GPs will not be informed of the care and treatment patients require in the community and

patients may not get the community based care they require. The trust was aware of this concern, there was an action plan to address it, and improvements were being monitored at board level.

Meeting people's individual needs

- There were arrangements in place to respond to the needs of patients with special needs and staff in all the areas we visited were aware of these. Staff told us there was a specialist learning disability nurse whom they could access for advice and support. Theatre staff told us there was a specific anaesthetists trained to provide anaesthetic services to patients with a learning disability. In theatre, staff told us that the majority of patients with a learning disability came into theatre for conditions related to the head and neck and that the oral and maxillofacial team had a specific care pathway for these patients. Staff said patients with a learning disability were usually scheduled at the end of surgical lists and there was a quiet section of the recovery area which was designated for patients with a learning disability.
- Patients living with dementia were assessed for mental capacity and we saw these assessments in all but one patient record. Where required, 'best interest' arrangements were followed in order to make decisions about patients' care and welfare.
- Most of the staff we spoke with told us they had not received specific training in caring for patients living with dementia. Ward staff told us they tried to comfort and support patients living with dementia but they were often unable to provide one to one care because there were not enough staff on the ward for this. We observed this in relation to a patient with dementia on ward E3 (ward for lower GI surgery) who demonstrated challenging behaviours and required considerable support. The ward was significantly short staffed and very busy. There was no capacity for nursing or support staff to provide one to one care.
- Staff on the surgical assessment unit raised concerns about the increasing number of patients requiring support for drug and alcohol addictions. Although specialist support for caring and treating these patients was available, staff said they could not always access this.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.

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- Patient information leaflets about different conditions and surgical procedures were available in the hospital and on the wards we visited. There was also information about surgical services on the hospital's website. Leaflets were only available in English.

Learning from complaints and concerns

- Patients we spoke with said they were not given information about how to make a complaint and were not always sure who they could complain to. Some patients who had made a complaint told us they received little or no response from the trust's patient advice and liaison service (PALS). We did not have information on PALS response times.
- Staff said they would direct patients to PALS if they were unable to deal with concerns directly. Staff told us patients would be advised to make a formal complaint if their concerns remained.
- Information related to complaints was reviewed at ward level and there were examples of action taken as a result. Staff told us they received feedback about complaints at team meetings and were able to give us examples of complaints and changes to services.
- Information boards on many of the wards we visited showed information about key concerns raised by patients and relatives and the ward's response. This took the form of "you said, we did" posters.
- Themes and trends from complaints were monitored at ward, clinical service centre, and board levels. The trust's quarterly quality report for quarter 3 2014/15 found that complaints across the trust were acknowledged within 3 working days but that complaints were not being resolved within the required 40 day timescales. The report showed, however, the time taken to resolve complaints was improving.

Are surgery 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.

Surgical services were not always well led and some aspects of leadership and management required improvement. There was no formal service-specific strategy across surgical services. However, the trust's clinical services strategy 2012/13–2015/16 identified unscheduled (emergency) care as and seven day working as key priorities. Managers were able to discuss the strategy and describe the challenges involved in implementing it.

There were clear clinical governance arrangements across most surgical services. Exceptions included arrangements for sharing quality and safety information with Ministry of Defence (MoD) staff and in ensuring standard operating procedures and protocols were up to date in pre assessment and theatres. Performance against operational and quality targets was monitored and action was taken when performance fell below expectations.

Key risks were identified and escalated to the trust's risk register. However, staff across a number of wards raised concerns about not being able to escalate risks beyond ward level. Risk registers did not always identify how risks were being managed and many interventions were out of date. Staff were also concerned that disciplinary action was sometimes being instigated unfairly, particularly in relation to their ability to manage pressure ulcers.

Surgical services engaged with patients mainly through the promotion of the friends and family test survey. Survey results across the trust's surgical wards showed patients and their relatives were generally pleased with the services provided, although they also showed there was room for improvement. Responses showed the trust was performing better than the national average.

Most staff we spoke with felt they could raise concerns and that their opinions were heard. They felt valued by their ward managers and their contribution to the operation of the ward was recognised.

However, there were mixed views from staff about the visibility of the senior leadership team for the trust, with some staff expressing a lack of engagement with senior managers.

Trust management recognised concerns about the sustainability of current service configurations across surgery, particularly in light of capacity challenges faced across the trust and the high volume of emergency procedures. Managers told us discussions with commissioners were underway to respond to these issues.

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Vision and strategy for this service

- The surgery and cancer clinical service centre (CSC) had a vision statement with objectives. However, there was no formal service-specific strategy across surgical services. The trust's clinical services strategy 2012/13–2015/16 identified unscheduled (emergency) care as an area in need of review and development. Managers were able to discuss the strategy and describe the challenges involved in managing capacity and demand for emergency surgery. They told us some action had been taken to meet the strategy's goals to increase the volume of elective surgery and separating elective and emergency but this had been limited by the scale of demand for unscheduled care.
- Another area prioritised in the trust's clinical service strategy was access to care 24 hours a day, 7 days a week (called 24/7 care). In surgery, we saw the trust had made significant progress against this objective. For example, general surgery had implemented a 'surgeon of the week' programme to better manage emergency surgeries and to ensure 24/7 consultant on call cover. In the musculoskeletal clinical services centre there was 24/7 consultant cover which was well established.
- Some individual surgical specialities showed a clear vision for developing their particular services. This included surgery and cancer as well as the renal transplant unit. Managers from the surgery and cancer clinical service centre described their plans to recruit, train and invest in their staff as well as the values they wished to embed within the service centre. They also explained their plans to reorganise surgical services in response to pressures in emergency surgery. Managers and staff in the renal transplant unit told about plans to extend renal services and make them more accessible. They also described their vision to work more collaboratively with commissioners and make the service more responsive to patients' needs.

Governance, risk management and quality measurement

- The service had monthly clinical governance meetings and these included a review of issues across different surgical subspecialties. Minutes from these meetings showed reviews of relevant NICE guidelines, incidents, audit results, complaints, concerns and risks. The meetings discussed audit, incidents, infection control findings, complaints and other feedback from patients.
- Clinical governance reports for individual clinical service centres were submitted to the trust's governance and quality committee. Included in these reports were analyses of audit findings, types of incidents, risks, and other quality metrics.
- There was a quality dashboard for each of the surgical clinical service centres and these showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- There were risk registers for each surgical clinical service centre and these identified relevant risks. Key risks were escalated to the trust's organisational risk register and reviewed by the trust board.
- Significant risks were identified on the theatre department's risk register. While we saw evidence that some of these were being managed, a number of the risks had been on the risk register for some time without resolution. For example, in 2012 a risk was added to the register regarding insufficient day surgery capacity. At the time of our visit, this issue was highlighted as a continuing concern. The risk register also indicated that the cardiac arrest alarms in theatre were identified as ineffective in June 2013. At the time of our visit, the concerns about the alarms had not been addressed. Reviews of standard operating procedures had been ongoing since 2012 and the last documented review of this risk was in February 2014.
- Risks related to individual surgical clinical service centres were known to the staff working within those clinical service centres and staff were able to discuss with us how the risks were being minimised.
- The wards we visited had regular team meetings in which performance issues, concerns, complaints, and general communications were discussed. Where performance fell below what was expected, ward staff were informed and action was taken in response.
- The trust identified that Ministry of Defence (MoD) staff on surgical wards were invited to team meetings and had access to the same information as trust staff. However the MoD staff were not aware of this felt and said there were no clear arrangements for ensuring information from incidents, complaints and audits were shared with them. Trust managers told us there was MoD representation at the trust's serious incident review group and on the trust's governance and quality committee. However, MoD staff on the wards we visited

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told us they were not sure whether they received feedback about the quality of care they provided and were not sure whether this information was shared with their superiors.

- Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings. With the exception of ward E3, lessons learned were routinely cascaded to staff within their respective clinical service centres.
- Although lessons from incidents and complaints were shared within the clinical service centres in which they were reported, lessons were not routinely shared across clinical service centres to ensure shared learning across the organisation.

Leadership of service

- The surgical clinical service centre was led by a chief of service, a head of nursing, and a general manager. Together they were responsible for monitoring the achievement of operational and quality targets, addressing and escalating risks, and leading on service improvements. When we spoke with these managers, they were able to describe the achievements, challenges, and risks related to their services and how these would be taken forward in line with the trust's clinical quality strategy.
- Each ward had a manager who provided day-to-day operational leadership to members of staff on their ward. Most staff we spoke with told us they felt well supported by their ward manager and that their manager had a visible presence on the ward. Some of the ward staff we spoke with told us they did not feel well supported by managers at clinical service centre level.
- However, staff on one particular surgical ward told us they received little support from their ward manager and that the manager was rarely seen outside their office. At the time of our visit, the ward manager was absent. There were no interim arrangements to ensure staff on the ward had managerial support. We found nurses in charge, who were not trained as ward managers, taking on the tasks of a ward manager in addition to their own duties. Severe staffing shortages on the ward also meant other staff took on multiple roles in order to provide adequate patient care and we saw this during our visit. Staff on the ward told us they

had raised concerns about staffing and management with the head of nursing for the cancer and surgery clinical service centre but that their concerns were dismissed.

- Ward managers we spoke with told us they felt well supported and were encouraged to escalate concerns. Most were aware of key risks related to their wards although almost all were unsure how some risks would be addressed. For example, managers were unclear about how concerns about ensuring patients (outliers) were placed on wards for their specific conditions were being addressed.

Culture within the service

- Staff were positive about the culture of the trust and generally described it as a good place to work. They were proud of the organisation's achievements and were keen to make improvements where these were required. There was a strong ethos of compassionate care and we observed examples of compassionate care from staff in all disciplines. We found staff worked hard to maintain a high standard of care despite difficulties with staffing and capacity.
- Staff told us they worked well together and could rely on the support and goodwill of their colleagues. We observed a high level of camaraderie and team work amongst staff. The only exception was in relation to Ministry of Defence (MoD) staff. We observed MoD staff working alongside NHS staff on surgical wards, however, they were not always well integrated with the established team on the ward. The MoD staff we spoke with said they enjoyed working alongside their NHS colleagues but that their leadership and instruction came from the Navy rather than from the trust. NHS staff told us this division in leadership between MoD and NHS staff sometimes resulted in MoD and NHS staff on the wards working in isolation.
- There were significant divisions within the colorectal surgery department and staff worked in what was described as a dysfunctional team. The trust had worked with the senior surgical staff to resolve issues and had engaged external mediation support and had sought legal advice where required. The processes followed were appropriate although they had taken some time to work through.
- Some staff raised concerns with us about the divisions within the colorectal team. Managers we spoke with recognised these concerns and had taken steps to

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improve team working within colorectal services. They told us more work was required to ensure the team worked cohesively and there was no evaluative evidence to suggest the concerns had had a detrimental impact on patient care.

- Staff were encouraged to raise concerns and to make suggestions for improvements, although there were some exceptions to this. On several of the wards we visited, staff expressed concerns to us about bullying and not being heard. This was specifically in relation to the management of pressure ulcers. The CSC management team told us that they had informed staff that they may face disciplinary action if they failed to care for patients appropriately, but not if it was beyond their control. However, ward staff and ward managers told us that they had been warned they would face disciplinary action if patients developed pressure ulcers, even if the reasons for the pressure ulcers were beyond their control. For example, staff were not always able to get pressure relieving mattresses for patients who needed them and were not always able to turn or move patients as often as required because there were insufficient staff. On ward E3, where there was a significant shortage of senior nursing and nursing staff, there were a high number of patients with pressure ulcers compared with other wards we visited and which were better staffed.
- Staff on several wards told us they were afraid to report incidents about pressure ulcers because they had been told by management that they would face disciplinary procedures if there were any further cases of patients developing pressure ulcers on the ward. We did not find evidence of disciplinary action but staff were concerned about the threat that this could happen.
- Where staff raised concerns with us, this was underpinned by a genuine interest in providing patients with the best possible care.

Public and staff engagement

- Surgical services engaged with patients mainly through the promotion of the friends and family test survey. Survey results across the trust's surgical wards showed patients were generally pleased with the services provided. Responses showed the trust was performing better than the national average, and highlighted some further areas for improvement.
- There was a trust-wide newsletter for members called 'Trust Matters.' This was used to communicate with

patients and other stakeholders. Issues we looked at included information on contacting the trust, changes to services, and information related to public health campaigns.

- There were other notable examples of patient engagement. Staff told us the clinical nurse specialist team held a focus group with patients in order to identify where improvements to services could be made. They said a patient survey conducted in December 2014 showed positive feedback in response to changes. Staff on the renal transplant unit described various initiatives to engage patients, including fundraising activities and collaboration with community stakeholders.
- Most staff we spoke with felt they could raise concerns and that their opinions were heard. They felt valued by their ward managers and their contribution to the operation of the ward was recognised.
- Staff were aware of the trust's 'Listening into Action' initiative which provided a means of direct communication with the chief executive for any member of staff who wished to raise concerns or make suggestions for improvements. Staff we spoke with were generally positive about the way in which their comments were received and acted upon. One example of a change made as a result included the restructure of the E level theatre complex's recovery area. In response to concerns raised by staff about skill mix, recovery was reorganised to ensure an appropriate mix of staff with a range knowledge and skills was on duty during each shift.
- There were mixed views from staff about the visibility of the senior leadership team for the trust. Staff on some wards told us they were visited by the chief executive and described this as a positive experience. Staff on other wards could not recall having been visited by senior management.

Innovation, improvement and sustainability

- Across the surgical services we visited, there was a culture of innovation and improvement which we observed at all levels. We saw many examples of innovation and good practice, a sample of which is listed below.
- Trust management recognised concerns about the sustainability of current service configurations across surgery, particularly in light of capacity challenges faced

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across the trust and the high volume of emergency procedures. Managers told us discussions with commissioners were underway to respond to these issues.

- On ward E2, staff told us there was a targeted and sustained programme of training and education to raise the skills of nursing and support staff on the ward. Staff and managers said they were proud of this achievement and the impact they felt this had on standards of care for patients.
- On ward D3, a specialist over 64s orthopaedics hip fracture ward, there was a dedicated orthogeriatric consultant who was based on the ward four days a week to provide specialist care and treatment. The consultant was part of the orthogeriatric team consisting of three nurse specialists and an administrator.
- There were good arrangements for meeting the needs of patients with a learning disability, particularly in theatres. Staff told us they had access to a specialist learning disability lead and could contact them for support if required. Staff showed good awareness of the specialist support that patients with complex needs sometimes require.
- Staff on the renal transplant unit described their efforts to engage patients in service development and

improvement. They told us about their efforts to raise money and how they used charitable monies to purchase equipment to improve patients' experience of renal care. Managers told us the department was developing its own National Vocational Qualification (NVQ) level 2 in renal care in collaboration with a local education provider. This was intended to establish and accredit basic competencies in renal care. Staff in the renal department produced an on-line video and told us the renal service had its own website to provide patients with information about their services.

- Surgical services included an early gastrointestinal (GI) cancer diagnostic centre that aimed to diagnose upper and lower GI cancers early and remove them without major surgery.
- The trust's colorectal team offered robotic colorectal surgery and Queen Alexandra Hospital was one of five hospitals in Europe, the only one in the UK, to be accredited as a training hospital for this type of surgery. As a designated training site for robotic colorectal surgery, colorectal surgeons from across Europe will observe trust surgeons performing surgery using the specialist equipment as part of their learning and development.

Critical care

Safe	Outstanding	☆
Effective	Outstanding	☆
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Outstanding	☆
Overall	Outstanding	☆

Information about the service

The intensive care unit (ICU) at Queen Alexandra hospital has 24 beds to provide care and treatment for critically ill patients. Three of these beds are funded for patients who require level 2 care, and the remaining 21 are for patients who require level 3 care and treatment. Level two beds are for patients who require higher levels of care and more detailed observation and/or intervention. The patients may have a single failing organ system or require post-operative care. Level three beds are for patients who require advanced respiratory support alone or basic respiratory support together with support of at least two organs systems, This level includes complex patients requiring support for multi organ failure.

Children's intensive care services are provided at Southampton General Hospital. However, there are occasions when children are treated and cared for in the ICU at Queen Alexandra Hospital. There are a team of nurses working on the unit who also have paediatric qualifications; there are medical staff on the unit who have paediatric qualifications and experience.

An Outreach Service is provided by the Critical Care Service. This service provides a specialist nursing team to give advanced clinical advice or treatment if a patient's condition is deteriorating on the general wards in the hospital. Their aim is to prevent patients having to be admitted to critical care beds. They also review all patients discharged from ICU to the hospital wards within the first 24 hours of their discharge

During the inspection of Critical Care Services we visited the Intensive Care Unit. We talked with three patients, seven relatives and 35 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 four care records. Before the inspection, we reviewed performance information from, and about, the hospital.

Critical care

Summary of findings

There were many areas of outstanding and innovative practices in the Critical Care service. Innovative daily safety briefings and the use of secure social media informed staff about risk to patients, the running of the service and learning from incidents. The environment and equipment were well maintained. There were innovative and imaginative ways of storing equipment which meant emergency equipment and information could be accessed promptly when required. This included airway equipment and information for staff about what to do in the event of major incidents.

Electronic records supported the effective assessing and monitoring of patients. Electronic recording of patient's vital signs in the general hospital allowed the outreach team remotely monitor deteriorating patients and prioritise which patients they attended to.

Staffing levels met patient's needs. Innovative practices and team working meant vacancies within the medical staff did not have an adverse impact on the wellbeing and safety of patients. This included consultants working in a registrar role to fill middle grade vacancies.

There was a strong and effective education programme for nursing, medical and allied health professional staff. Where possible there was a multidisciplinary approach to education. In partnership with the University of Portsmouth the unit was developing an Advanced Critical Care Practitioner course. However, for trust required mandatory and essential training, medical staff had not complied with the target set by the trust.

Feedback from patients and their relatives strongly evidenced there was a caring and supportive culture in the critical care unit.

The trust had the foresight to plan for the expansion of the service when designing and building the unit in 2009. There was capacity to expand the unit to 36 beds. National data showed that the unit performed worse than similar units for discharging patients to wards out of hours (between 10pm and 7am). The unit had taken action to mitigate any risk this posed, with the use of detailed discharge summaries, verbal hand overs and ensuring all medicines had been administered prior to the patient being discharged.

Information for relatives and patients about the unit were available in leaflets and on the unit's own website. However the information on the website was not easily accessible to people who had a disability that made it difficult to read or understand written words.

To reduce the risks for patients located elsewhere in the hospital requiring critical care the unit had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care retrieval team in the ED, before admission to the unit. This also happened for patients requiring admission to the unit from the general wards.

There was a strong, supportive and effective leadership of the service. Staff were supported to develop leadership skills. The culture of leadership resulted in a no blame culture where lessons were learnt from incidents and mistakes without blame being apportioned to staff.

Innovative ideas and approaches to care were encouraged and supported, many of which were enhancing patient safety and experience on the unit. This included the use of information technology and social media to enhance patient safety, the practice of daily safety briefings, the continued development of the electronic patient recording system, and the use of grab packs to give staff instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.

Critical care

Are critical care services safe?

Outstanding



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

We rated safe as outstanding.

Process and procedures were followed to report incidents and monitor risks. A wide variety of processes were used to alert staff to risks, incidents, near misses and learning from these incidents. An innovative practice of daily safety briefing on the unit, involving the full multidisciplinary team identified risks to patients, risks to the performance of the unit, actions required to mitigate any risks and learning from recent incidents. The unit was innovative with the use of information technology in supporting staff awareness of safety and risks. Electronic 'Watch out' screens on the unit displayed details about recent incidents, the learning from them and details about entries on the unit's risk register. Social media, including secure Facebook and Twitter accounts, informed staff about risks and safety issues.

Infection control practices were followed. There were low numbers of unit-acquired infections, with the unit having no unit-acquired MRSA infections since November 2012. The environment and equipment were well maintained. Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.

There was effective management of medicines; prescribing was electronic. Computers at bedsides were locked to the specific bed space and patient. This reduced the risk of medicines being prescribed for the wrong patient. Innovative electronic recording systems supported the effective assessment and monitoring of patients. Processes were followed to ensure records were secure and confidential. Back-up systems ensured monitoring continued and records were not lost in the event of equipment failures.

Safeguarding procedures were followed to protect vulnerable adults from abusive situations.

The trust set a target of 85% compliance for all staff with mandatory and essential training; generally, this target was met. The outreach team responded to requests to assess deteriorating patients in the general hospital. The hospital's electronic monitoring system for recording patients' vital signs enables the outreach team to remotely monitor patients' conditions and prioritise which patients they attended to.

Staffing levels met patients' needs. Strong team working meant vacancies within the medical staff did not have an adverse impact on the wellbeing and safety of patients. This included consultant staff volunteering to cover vacant middle-grade roles by working shifts as registrars. The team were also innovative and were developing the advanced care practitioner role to cover some of the duties done by medical staff.

The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.

Incidents

- All staff in the critical care department who we spoke with knew how to escalate and report incidents. This included senior and junior medical staff, allied healthcare professionals and nursing staff of all grades.
- Incidents were reported using an electronic reporting system. Staff reported that it was easy and quick to use. Guidance about using the system was provided in training and staff had access to an information folder that held this guidance.
- The service used many ways to ensure staff received feedback about incidents. The incident-reporting guidance folder gave information about learning from incidents. The innovative use of 'Watch out' electronic screens on the unit displayed details about recent incidents and what was learnt from them. The daily 'Safety Brief' discussed incidents and near misses and the action and learning taken in response to these incidents. The unit also had a Twitter account that staff could access to see updated risks and learning from incidents.
- The practice of Mortality and Morbidity meetings was embedded into the running of the unit. (Mortality and morbidity meetings are peer reviews of mistakes occurring during the care of patients with the objective to learn from complications and errors and to prevent repetition of any errors leading to complications.)

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Meetings were alternate months and were attended by the multidisciplinary team and invited external specialists. Both nursing staff and pharmacy staff confirmed they attended the meetings along with the medical staff. Records of the meetings showed all deaths within 24 hours of admission and deaths that were not anticipated were reviewed. The results and learning from these meetings fed into the trust's Mortality Report Tool. This is an advanced tool for recording, analysing and reporting mortality. It supports mortality outlier investigation and is currently considered as best practice nationally.

- There were 13 reported incidents that related to the intensive care unit (ICU) in the period July 2014 to end of January 2015. Twelve of these were pressure ulcers, 11 of which were present on admission to the unit. Only one developed on the unit and an investigation of the cause was completed. The 13th incident regarded an adverse reaction to an antibiotic.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS
- Information about duty of candour was displayed on posters throughout the unit.
- Staff knew about the process and knew where they could find guidance regarding the duty of candour process.
- The electronic incident reporting tool included a prompt for staff to consider whether the duty of candour process needed to be followed. Staff had to indicate on the report that they had considered this.
- There had been one incident that required the duty of candour process to be followed since the introduction of the legislation in November 2014. This was completed as per process

Safety Thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. Patients, visitors and staff could access Safety Thermometer information, which was displayed on information boards at the entrance to the ICU. This included information about falls with harm, new venous thromboembolism, catheter use with urinary tract infections and new pressure ulcers.
- Safety Thermometer results for the ICU detailed for the year January to December 2014 indicated there had been one unit-acquired pressure ulcer, one patient fall resulting in moderate harm and one unit-acquired venous thromboembolism. There had been no catheter-related urinary tract infections, all patients had been risk assessed for likelihood of venous thromboembolism and where required treatment to reduce risk of VTEs occurring had been given.

Cleanliness, infection control and hygiene

- Rates for hospital acquired infections were low. Data from the trust showed there had been no unit-acquired MRSA or MSSA since November 2012.
- The unit had in internal target to have no unit-acquired cases of *Clostridium difficile* for the year April 2014 to March 2015. (*C. 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.) There had been two cases of *C. difficile* in April 2014. Root cause analysis had been completed and appropriate action had been taken in light of the findings of this investigation. Advice had been sought from the hospital's infection prevention team.
- Data from the Intensive Care National Audit and Research Centre detailed that rates of unit-acquired MRSA and blood-borne infections were less than those of similar critical care units. The rate for *C. difficile* infections was similar to that of similar critical care units.
- Cleaning of the unit was subcontracted to another provider. The unit had three permanent cleaners, one for each of the clinical sides of the unit and one for corridors and offices. If one of the cleaners was on leave, the cover cleaner was given the non-clinical areas to

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clean. Staff found this ensured cleaning of clinical areas was maintained at a high standard. Cleaning audits evidenced this, with the unit meeting the hospitals standards for the past year.

- Personal protective equipment, such as gloves, aprons, glasses and face masks, were available. We saw staff used this equipment when providing patient care and treatment, and disposed of the equipment after they had completed the episode of care.
- Different-coloured aprons were used for each bed space; this meant it could be easily identified if staff did not change aprons between caring for different patients. Different-coloured flooring in bed areas promoted staff to consider whether they needed to use personal protective equipment.
- The unit had side rooms with lobbies and airflow systems to help prevent the spread of air-borne organisms.
- Following the trust's policy, all patients were screened for MRSA on admission to the unit, treated prophylactically and rescreened five days later.
- There was a unit infection control team that included medical and nursing staff to support staff with infection control practice.
- Microbiology ward rounds three times a week provided advice on the use of antibiotics and treating of infections.
- Hand cleaning facilities, including hand gels, were available at the entrance to the unit and throughout the unit. There were notices advising visitors to wash their hands to reduce risks of cross infection. Hand hygiene audits showed that compliance with hand hygiene was between 98.7% and 100%. This was meeting the trust's requirements for hand hygiene.

Environment and equipment

- The unit was secure and access was by key pad. Visitors were welcomed to the unit by reception staff during working hours and by clinical staff at night.
- Resuscitation equipment that included equipment for the management of airways was available on each side of the unit. This was kept in identical trolleys on each side of the unit, with the equipment stored in an identical manner. There was innovative and practical planning of the equipment stored on this trolley. Routinely used equipment to manage patients' airways was stored in the top drawer, with equipment used for the management and treatment of difficult airways,

including surgical management of difficult airways, in lower drawers. Each drawer was clearly labelled. This meant that all equipment for the management of airways was located in one trolley that could be transported to the patient who required assistance, rather than staff having to get equipment from a variety of storage areas. The equipment on the trolleys was checked daily and replenished after equipment was used.

- There was dedicated equipment that was taken to the emergency department (ED) and other wards when critical care staff were treating and retrieving patients from these areas. This meant patients in all areas of the hospital had access to critical care treatment equipment.
- Staff said that essential equipment was always well stocked, with individual patient trolleys being filled up each shift. The hospital had an equipment library that wards and units could use to get equipment. However, staff said the unit rarely needed to use the equipment library, but when they did the equipment was readily available.
- We saw on visual inspection that medical equipment, including mechanical ventilators, renal replacement machines, infusion and feed pumps, were clean, serviceable and when not in use stored correctly; they were all in date for servicing and portable appliance testing.
- The unit had a dedicated member of staff for ordering and ensuring stock levels of equipment were maintained.
- 'The Kit bag' equipment newsletter shared problems and solutions relating to equipment used on the unit and in the hospital.

Medicines

- The ICU had two allocated pharmacists who provided a service to the ICU and theatres. At the time of our inspection there was only one pharmacist covering both areas, but a new pharmacist had been recruited and was starting employment in March 2015.
- Electronic prescribing was practised on the unit. Computers at patients' bedsides were locked to the specific bed space and patient, which meant prescribing for that patient could only be done at their bed space. This reduced the risk of medicines being prescribed for

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the wrong patient. Changes made to prescriptions were routinely checked by the pharmacist to ensure the medicines were prescribed correctly and were appropriate for the patient.

- The pharmacy department completed audits regarding missed medicine doses. An audit of 18 patients in critical care services in June 2014 showed there had been no incidents of missed doses for those patients.
- The electronic system detailed patients' allergies, but at the time of the inspection did not follow through to the discharge summaries. This concern had been raised by staff who hoped upgrades to the electronic system would enable drug allergies to be pulled through onto discharge summaries. To mitigate the risk of discharge wards not having information about drug allergies, discharge summaries included a transcribed hand written drug chart which detailed when the last dose of each drug was administered and any known drug allergies and detail of when the last dose of each drug was administered. Patients wore a wrist band that identified any known allergies.
- Medicines were stored in secure areas. Medicine preparation rooms were secure, with members of the public not being able to access the rooms. Access was gained to these rooms via a key pad. Patients own medicines were stored in a locked draw in the patient's bed space. Controlled medicines were stored in a locked cupboard that complied with the trust's policies. The keys to access the controlled medicines were held by the shift team leader, in order to minimise confusion as to where they were. Medicine fridges were kept within cold storage limits and a register of these were kept daily.
- Nursing staff said they received training about the safe administration of medicines and could only administer medicines after they had completed competency assessments. Trust records showed that nursing staff had a 94% compliance with medication management training.

Records

- Electronic patient records were used on the unit. Each bed space had a computer locked to it where the patient's records were entered onto. Most equipment used to support and treat the patient such as the ventilator; monitor and infusion pumps were connected to the computer. This meant there was a continual

recoding of patient observations and wellbeing, trends in their condition could be identified and there was no risk of measurements of observations being recorded inaccurately.

- All medical and nursing notes were recorded in the electronic recording system. There were clear prompts for both medical and nursing assessments, care planning and risk assessments. We saw the prompts were used to complete assessments and develop care plans.
- Patient allergies were identified by a red triangle icon that when clicked detailed the allergy and the effect that had on the patient.
- Staff were prompted to complete tasks by a red flashing icon which they clicked on to find out which tasks were due for completion. The icon could be clicked at any time to view the task lists for the 24 hours.
- All patients' lines, drains etc. were detailed on a body map as well as any wounds, injuries or bruises.
- All notes entered onto the electronic recording system were dated, timed and the name and designation of the person entering the details was recorded.
- All data inputted into the record was automatically fed into the discharge summary which was printed off in paper format for the ward the patient was going to.
- All staff had personal log in details for the electronic record system; ensuring information was secure and remained confidential.
- Staff told us the system was quick and easy to use. They felt the prompts for monitoring and attending to the patients' needs enhanced the patient's safety. They felt the system helped to free up nursing time, giving more time to be focused on patient care rather than writing notes.
- There was a team of nursing and medical staff who assisted in the development of the electronic recoding system. Staff could suggest changes to the system that could be implemented in updates to the system.
- At each bed space there was facility for paper notes that the patient had prior to being admitted to the unit to be stored in a locked drawer. If the notes were no longer required there was availability to lock them in a secure area in the secretary's office.
- There were back up systems to ensure data was not lost and processes were in place to ensure monitoring was recorded in the event of power outages.

Safeguarding

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- Review of incident reporting for critical care showed that safeguarding referrals were made appropriately. This included referrals being made for patients where it was reported they were living in inappropriate environments and there was concerns they were being financially abused by landlords or family members. We saw documentary evidence that the safeguarding processes were instigated in these cases.
- Training records dated 30 January 2015 showed that staff compliance with safeguarding of vulnerable adults training was for medical staff 82% and nursing staff 96.5%. For safeguarding children, medical staff had a compliance rate of 75% for level 1 training and 38 % for level 2 training. For nursing staff the compliance was 100% for level 1 and 89% for level 2 which was above the trust's requirement of 85% compliance. Records showed that administration and technical staff completed training in safeguarding children but not in safeguarding adults. Records provided by the trust showed that level 3 training about safeguarding children was not a required training for staff working in critical care. However, nursing staff who had completed the paediatric nursing course, said safeguarding children was a significant component of their training. They described how they passed their knowledge on to other staff on the unit. They gave an example of how they had influenced changes in practice on the unit to protect children. This included the doors to the child's room remaining closed so it was less evident there was a child on the unit with the view to enhancing their protection. They also discussed their awareness that the impact of an adult being admitted to the critical care unit might result in the welfare of any dependent children being adversely affected and that in this scenario processes would be followed to ensure the children were safeguarded.

Mandatory training

- The trust reported that mandatory and statutory training covered life support, fire safety, health and safety, manual handling, blood awareness, medicines management, information governance, infection prevention and control, complaints and concerns, risk management, prevention of violence and aggression, safeguarding vulnerable adults, safeguarding children and dementia awareness.
- Staff reported they were motivated to keep up with their mandatory training. Nursing staff reported they had 45

minutes every day during the handover period which they could use to complete online training and attend training sessions. We saw staff completing on line training using the bedside computers.

- Records provided by the trust showed that nursing staff constantly achieved above the required 85% compliance with mandatory and statutory training. Medical staff, however with the exception of blood awareness, scored below the 85% target for compliance. Their compliance rates ranged from 38% to 86%, with the majority of their compliance rates being between 75% to 82%. New starters who were presently working through the mandatory training programme had an impact on the compliance figures.

Assessing and responding to patient risk

- In order to ensure all members of staff were aware of potential risks to patients the unit had implemented an innovative practice of safety briefs daily at 10.55am on the unit. We observed two safety briefs during the course of the inspection. This was a multidisciplinary meeting where safety issues on the whole unit were discussed so all team members were aware of them. They were attended by a mix of the staff on duty which included medical staff, nursing staff, and allied health care professional. Issues discussed included any patient allergies, airway concerns, infection control issues, sedation holds in process, capacity in the unit and staffing levels for, medical, nursing and allied health care professional. Clinical incidents were discussed with resulting learning from the incident. The process took no longer than 10 minutes, and for staff who was not able to attend the brief, the information was cascade through the shift leaders.
- There was a critical care outreach team that consisted of nursing and medical staff. They offered a review of all patients discharged from intensive care to the general wards in the hospital on a daily basis.
- The hospital had a deteriorating patient policy (version 2 January 2014, review date December 2016) that detailed referral to the critical care outreach team should be considered for any acutely ill or deteriorating ward inpatient who is causing concern. The electronic monitoring system used in the hospital for monitoring patient's vital signs enabled the outreach team to view the monitoring of patients on all wards. This meant they could prioritize which patients they assessed in order of clinical need.

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- The outreach team integrated with the “Hospital and Night” team. There was a handover between the two teams in the morning and in the evening to identify patients in hospital whose clinical conditions were a concern.
- The team provided regular teaching sessions to other wards to raise awareness of the service.
- The outreach team also provided a tracheostomy support team, supporting the general wards to care for patients with tracheostomies. Every patient in the hospital with a tracheostomy was followed up by the outreach team. The team had created a ward information pack and had provided information for the trust intranet to support staff with caring for patients with tracheostomies and there was also information for patients about tracheostomy care on the trust’s website. Staff said the electronic recording system prompted them to complete essential safety checks, which helped reduce risks posed to patients.
- Risk assessments were completed for patients. These included assessments for the risk of developing pressure ulcers, venous thromboembolism (blood clots), malnutrition and falls. Where risks were identified the action required to reduce or manage the risk was detailed.

Nursing staffing

- Nurse staffing levels followed national guidance. Level 3 patients were nursed on a one to one ratio and level 2 patients were nursed on a two patients to one nurse ratio. Staff reported that staffing numbers were sufficient to ensure staffing numbers were in line with the recommended guidelines
- Some staff reported that the unit ‘lost good nurses’ because there was a lack of career promotion and progression. This was because there was a stable senior workforce, which created difficulties for staff to progress their career without leaving the unit.
- There was very little use of agency staff which meant the unit met the national guidance that no more than 20% of the work force on any shift should be agency nursing staff. The duty rota showed that for the three month period December 2014 to end of February 2015 the unit had used one member of staff from an agency. This member of staff been used on a regular basis, which ensured continuity of care for patients.
- The risk register for critical care detailed there was an inherent risk of sudden staff shortages due to military

nursing staff being deployed elsewhere. However, as part of the agreement with the military services, processes were in place to ensure extra staffing was funded by the military if perusal had to be deployed urgently in an unplanned manner.

- The unit employed three research nurses. The research nurses felt it would be beneficial to have more research nurses as they could then provide a 24 hour service and ensure all eligible patients were entered on trials if they wished to.
- There were always two outreach nurses on duty each day. However, sometimes one of these nurses had to cover shifts on the unit which reduced the number of outreach nurses to one.
- There was high number of nursing staff who had a post registration qualification in critical care nursing, 80%. The Intensive Care Society had a minimum standard of 50%. This meant that patients were cared for by nurses who had the appropriate skills and qualifications.
- Staffing levels were displayed at the entrance to the units.
- Each side of the unit had a nurse in charge of that side who was supernumerary to the staffing numbers, and one of these nurses took overall charge of the unit. Given the critical care unit accommodated a maximum of 19 level 3 equivalent patients, they were meeting the national guidance with two supernumerary nurses on duty. They were also able to call on the support of educational and outreach nursing staff to support the unit when required. Night staffing levels were set higher to reflect the fact that educational and outreach nursing staff were not available to be called on if needed.

Medical staffing

- The risk register for Critical Care service detailed there was a shortage of medical staff. This particular related to difficulties with recruiting middle grade doctors (registrars). This problem is not specific to the critical care unit at Queen Alexandra Hospital, but is a national concern. To address this issue the unit had previously recruited middle grade doctors from Australia, supported by the fact the unit was accredited by the College of Intensive Care Medicine of Australia and New Zealand to deliver critical care medicine training. .
- Consultant staff covered vacant middle grade roles by working shifts as registrars. Patient’s records clearly detailed whether the consultant was working in their consultant role or in a registrar role.

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- It had been recognised that this way of working was not sustainable. Recruitment for more consultants had been approved by the trust and was ongoing. In collaboration with the University of Portsmouth the unit was developing innovative two year courses to train advanced critical care practitioners. It was envisaged the advanced critical care practitioners would relieve medical staff of routine medical duties allowing them to attend to the more intricate medical roles. It was planned that this training, the entry criteria for which was the first of its kind, would commence in autumn 2015.
- During the day there were two consultants on duty for clinical duties and at night one consultant on duty for clinical duties. This meant if all beds were occupied there was a ratio of one consultant to 12 patients during the day and one consultant to 24 patients at night.
- It was reported by all staff there was a high level of involvement by all consultants in the care and treatment of patients both during the day and at night.
- Risk register for the critical care service detailed there was an inherent risk of sudden staff shortages because of military medical staff being deployed elsewhere. However, as part of the agreement with the military services, processes were in place to ensure extra staffing was funded by the military if staff had to be deployed urgently in an unplanned manner.

Major incident awareness and training

- There was an emergency planning board located in the main corridor in the unit. This had grab packs that had details of the action that had to be taken in the event of major incidents. There were grab packs for departmental contingency and continuity, utility failure, emergency telephone breakdown and major incidents. Staff were aware where these packs were located and knew they provided all the detail the nurse in charge needed to ensure appropriate action was taken in the event of any of these circumstances arising.

Are critical care services effective?

Outstanding



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 outstanding.

Treatment and care provided followed current evidence-based guidelines. The critical care service participated in national and local audits in order to measure its effectiveness. Data from audits showed there were good outcomes for patients being treated in the critical care service. There was an established programme of auditing the service, the findings of which influenced changes and improvements in the service.

There was an established process for assessing and monitoring patients' pain, agitation and delirium that made use of nationally recognised monitoring tools.

Despite not having a dietician based on the unit, patients' nutritional and hydration needs were met with the support of a staff group that had a special interest in nutrition. All patients received nutrition within 24 hours of admission to the unit.

There was a strong and effective education programme for nursing and medical staff. Where possible there was a multidisciplinary approach to education. There was opportunity for presentations in medical education meetings and they were attended by the full multidisciplinary team. Staff confirmed this occurred. Junior doctors' induction programme included a shift working with a nurse to enable them to understand the critical care nurses' role. The unit was the only unit in the UK accredited to provide training by the College of Intensive Care Medicine of Australia and New Zealand. In partnership with the University of Portsmouth, the unit was developing an innovative Advanced Critical Care Practitioner course.

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There was a dedicated nurse education team on the unit. There was a commitment to support nurses in attaining post-registration critical care qualifications, demonstrated by the fact that 80% of the nursing workforce had a qualification in critical care nursing.

Multidisciplinary working was embedded into practices in the unit. A dedicated team provided follow-up services for patients once they had been discharged from hospital. Outreach nurses provided support for wards and patients within the first 24 hours of discharge to a general ward. However, this service was slightly compromised because it was not staffed for 24-hour cover.

Seven-day services were in place that included medical, nursing, physiotherapy, pharmacy and diagnostic services.

The innovative electronic recording system meant that all staff had instant access to patient information. 'Watch out' electronic screens, Twitter and Facebook accounts and email facilities provided information to staff. There were enough computers in the unit, at patients' bedsides and within the unit, for staff to easily access information.

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

Evidence-based care and treatment

- The critical care unit's care practices followed current evidence-based guidance. Policies were accessible for staff and were developed in line with national guidelines such as the National Institute for Health and Care Excellence (NICE) guidelines for temperature control after cardiac arrest and the Intensive Care Society (2009) standards for renal replacement therapy. We observed a medical handover during which the conversation showed that evidence-based treatment was carried out.
- Nationally recognised care bundles were followed, which included care bundles to reduce the risk of ventilator-acquired infections and central line infections and complications.
- Critical care services took part in a number of national audits to measure the effectiveness of care and treatment provided. Some of these audits included data submitted to the Intensive Care National Audit and Research Centre and the National Cardiac Arrest Audit.

- There was a lead consultant for audits. The annual audit report reviewed the multiple audits that had taken place, the nominated member of staff who owned that audit programme and action taken as a result of the findings of the audit. Some audits were large-scale audits such as auditing admission of patients with liver conditions. Others were small-scale audits, carried out over the course of one day, such as an audit of nurses' awareness of junior doctors' allocations.
- Changes made to the service provision as a result of local and national audits included the commissioning of five extra beds to assist in reducing delayed admissions, discharges and discharges out of hours.
- In June 2013 the physiotherapist lead had audited the unit's compliance with the NICE guidelines for rehabilitation of critical ill patients. The audit had evidenced the service was not compliant with this guidance. Re-auditing in December 2014 showed significant improvements had been made and an action plan was being followed to ensure full compliance with this guidance.
- The Core Standards for Intensive Care Units 2013, state "All patients will be screened for delirium.....with a standardised assessment tool and use a multi-professional, multi-modal approach." The critical care unit was meeting this standard.

Pain relief

- Patients' pain was monitored by following the hospital's sedation and delirium in critical care protocol, which gave guidance on the management of pain, agitation and delirium. This incorporated pain scores that were measured in line with patients' nonverbal communication and behaviours, as well as the internationally recognised Richmond Agitation-Sedation Score, which would identify if a patient's agitation could be caused by pain.
- There were clear guidelines about preferred analgesics to be used for mild, moderate and severe pain and about the frequency for recording patient's pain levels. The electronic recording system prompted nursing staff to monitor patients' pain levels.
- Staff who we spoke with had a clear understanding of the sedation and delirium protocol and explained how it was used to monitor and record patients' pain levels.

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- The intensive care unit (ICU) had its own pain management group who attended relevant training and offered support and guidance in the management of pain relief. When needed, staff could access the trust's pain relief team for further advice and guidance.
- Patients who we spoke with said their pain was well managed.

Nutrition and hydration

- The electronic recording system prompted assessments of patients' nutritional status and associated risks at the time of admission to the unit.
- The unit had a consultant lead for nutrition. Protocols for managing patients' nutrition were evidenced-based. The unit had taken part in the national Calories trial. (This was a national trial to determine whether there was any increased morbidity associated with the use of enteral or parenteral feeding initiated on admission to intensive therapy units.) All patients received nutrition in the form of enteral or parenteral nutrition within 24 hours of admission to the unit.
- The unit did not have a dedicated dietician, which was not in line with national guidance. However, the unit had developed its own nutritional team that consisted of the consultant lead for nutrition and a team of nurses. The trust nutritional team was contacted for support and advice if needed.
- The critical care pharmacists monitored the prescribing of parental nutrition to ensure it was a safe prescription for patients. The make-up of parental nutrition was completed by a separate pharmacy team that was not based on the hospital site.
- We observed staff supporting patients to eat in a sensitive manner. Patients, when able, sat out or up to have their meals. All patients who we spoke with commented that they had enjoyed their meal.
- Staff said it had previously been noticed that the housekeeping staff delivering meals to the unit did not always inform staff that they were there. This had sometimes meant that meals had gone cold because staff had not been notified they were on the unit. Processes had now been changed so that when the meals were delivered to the unit a member of staff was always notified. This meant patients received meals that were warm.
- Nutrition and hydration was monitored with the use of the electronic recording system.

Patient outcomes

- The trust stated they were one of the top-10 critical care units in the country for survival data. Intensive Care National Audit and Research Centre data showed that mortality rates were below (better) than those of similar units.
- Data for unplanned readmission to the unit within 48 hours showed the unit was performing at a similar rate to other similar critical care units.
- Intensive Care National Audit and Research Centre data showed that MRSA and blood-borne infections were lower (better) than those of similar units.
- The same data collection showed that although the unit was performing better than similar units for delayed discharges out of the unit of over four hours, they were performing worse for discharges occurring out of hours.
- Locally an audit of patients referred but not admitted to the ICU had been completed. An audit of referrals to the outreach team completed in March 2014 showed that an average of three patients were referred daily. Of these referrals, 21.5% were admitted to the ICU. For 56.8% of these patients, with the assistance of the outreach team, their conditions improved on the ward. For 10.2% there was no further treatment that could be offered and 1% of the patients referred died. Local audits were being completed for sedation and delirium, and end of life care.

Competent staff

- One of the ICU consultants had an intensive care medicine training role managing the junior medical staff training; all junior medical staff were assigned an educational supervisor who saw them at prescribed intervals.
- Junior doctors commented that the unit had a "strong and good" reputation of training and experience on the job. Their experience of working on the unit had so far confirmed that statement.
- The General Medical Council survey of trainees completed in 2014 showed a high level of satisfaction from trainees about the support and training they received on the unit. For induction training, handovers, access to educational resources and local training, trainees scored their experience as better than the national average.
- Junior doctors confirmed they had met their educational supervisor. They said they had received a

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detailed induction, which included the electronic recording system, infection prevention practices and the unit's process. They confirmed they had their competencies assessed at the beginning of their attachment to the unit and were working within their assessed competencies. Part of their induction process included a shift with the nursing staff so they understood the role of the ICU nursing staff.

- Junior doctors had individualised action plans for their learning needs, which were adhered to. Junior doctors described the working rotas were flexible to accommodate external training needs.
- Weekly four-hour education meetings were held on the unit. This included a journal club, where papers were presented by one of the registrars, core curriculum training for all doctors, case presentations and multidisciplinary topics presented by other specialists. The multidisciplinary part of the meeting was open to the multidisciplinary team that included, but was not exclusive to, nursing, physiotherapy, Ministry of Defence, and pharmacy student staff. Mortality and morbidity meetings were utilised as a learning resource and were also attended by the multidisciplinary team.
- The critical care unit had developed its own innovative website that included educational information and guidance documents. There was guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.
- The unit also ran a successful regional revision course for Final Faculty of Intensive Care Medicine exams (Portsmouth Intensive Care Exam Revision Pincer course) with contributions from all consultant staff. There was positive feedback from this course, including "Excellent course, very helpful and supportive faculty. Would highly recommend", "Friendly, encouraging faculty, on the whole very well planned and organised. Excellent course" and "Practice brilliant. Friendly faculty: credible examinations."
- We observed a consultants meeting during which the training needs of junior doctors were discussed. The views of all consultants were considered in identifying the strengths, weaknesses and training needs of the junior doctors. Actions for education supervisors were suggested.
- The unit had formed a collaborative partnership with the University of Portsmouth in 2013 with the purpose of providing greater learning and research opportunities for junior medical staff.
- In response to difficulties recruiting middle-grade (registrar) doctors, the unit, in partnership with the University of Portsmouth, was developing a two-year course in Advanced Critical Care Practice (ACCP). It was envisaged the ACCPs would relieve medical staff of routine medical duties allowing them to attend to the more intricate medical roles. It was planned that this training, the entry criteria for which is the first of its kind, would commence in autumn 2015. We viewed correspondence from Health Education Wessex dated 24/1/2015 commending the high-quality training provided by the unit, the fact that trainees are encouraged to work in clinical trials, the innovative IT service and that the unit remains the only unit in the UK that is accredited to provide intensive care medicine training by the College of Intensive Care Medicine of Australia and New Zealand.
- Nursing and allied healthcare professionals' education was coordinated by the unit's nurse practice educator who had the role for critical care anaesthetics and theatres. She was supported by a team of two regular practice educators and a band five or six nurse who rotated into the team from the critical care unit. All members of the education team maintained 50% of their working time in clinical practice in addition to the education role, to ensure they remained current with clinical skills.
- 80% of critical care staff had completed further specialist training in intensive care nursing; this is above the Intensive Care Society guidance that at least 50% of nursing staff in a critical care setting should have a post-registration qualification in critical care nursing. This meant patients were cared for by staff who had specialised training and skills.
- Each year the unit supported eight members of staff to complete 20 credits training at degree or master's level in intensive care nursing and a further eight staff to complete the same in high dependence nursing and a local university. Staff on this 'top up' degree pathway were encouraged to undertake diverse modules, for example leadership and pain management.
- Junior staff had various avenues to continue professional development; one example was the rotational posts that were available. Junior staff could

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apply through internal processes to spend a fixed period of time working alongside a specialist team. This could include the critical care outreach team, retrieval team or the practice development and training team.

- Each year, one qualified intensive care nurse was seconded to undertake a conversion course in paediatric nursing. This was part of the plan to ensure there were sufficient numbers of paediatric nurses to care for children admitted to the unit.
- The education team maintained a staff training noticeboard where details of upcoming training were made available. We saw training was available for both qualified nurses and healthcare support workers. Training included critical care topics, care of patients living with dementia and care of the dying patient.
- Training planned on the unit was accessible to Ministry of Defence staff working on the unit.

Multidisciplinary working

- There was an embedded practice of multidisciplinary working. This was clearly displayed in the practice of daily safety briefs that included all of the multidisciplinary team.
- Nursing and medical staff reported there was no divide between nursing and medical staff. Junior doctors were required to spend a shift with the nursing staff during their induction to enable them to understand the intensive care nurses' role.
- A band five nurse described the medical team as very collaborative and supportive of nursing staff. Junior nurses were encouraged and given responsibility by medical staff to complete tasks such as bedside handovers and take part in the ward rounds.
- The unit worked closely with the specialist nurse for organ donation who was based on the unit to provide support for families whose relatives wished to donate organs in the event of their death.
- Technicians supported staff with the management of equipment.
- Physiotherapists were attached to the unit and worked collaboratively with the nursing and medical staff to ensure patients received the support they required.
- The outreach team provided a follow-up service to all patients discharged from the unit in the first 24 hours. However, this was slightly compromised by the fact that the outreach service was not staffed for 24 hours' cover.
- There was an effective working relationship with the children's intensive care services at Southampton

General Hospital. All children who required airway support were discussed with the clinicians at Southampton General Hospital and, when the child's clinical condition allowed, they were cared for in the critical care unit at Portsmouth rather than undergo the stress of being transferred to Southampton General Hospital.

Seven-day services

- The service had intensivist cover on site 24 hours a day, seven days a week.
- A physiotherapy service was available 24 hours a day, with the service being an on-call service at night and the weekend. Staff said there was no delay in obtaining physiotherapy support and treatment for patients out of hours and at weekends.
- There were pharmacy and pathology services available seven days a week, with out of hours being an on-call service.
- The outreach team provided a service seven days a week; however, this was not a 24-hour service, which was not in line with national guidance. This meant patients discharged in the evening might not have a review of their condition by the outreach team for up to 12–16 hours after their discharge. The risks to patients in this situation were mitigated by the head of nursing on duty for the hospital at night team reviewing patients who had been discharged from the ICU. However, this nurse did not have the same clinical expertise as the outreach nurses. At night, concerns about deteriorating patients were directed to the medical staff rather than the outreach team. The outreach team integrated with the Hospital at Night team. There was a handover between the two teams in the morning and in the evening to identify patients in hospital whose clinical condition was a concern.
- Imaging (x-ray) services were available out of hours with a core team of staff on site during the day and an on-call system overnight.

Access to information

- The electronic recording system meant all staff had instant access to all information required to provide individualised, safe care and treatment to patients.
- There was effective and innovative use of electronic and IT systems to provide information to staff. This included

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the use of safety screens, Twitter and Facebook accounts and email facilities. There were enough computers in the unit, at patients' bedsides and within the unit, for staff to easily access information.

- All staff had trust email accounts so they could access updates electronically.
- Communication files were kept for staff to access up to date information.
- Noticeboards in staff areas clearly displayed information updates on topics such as pressure ulcer prevention, infection control practices, the Mental Capacity Act 2005, safeguarding, and duty of candour processes.
- Staff meetings were held in which information was cascaded; records were kept of these meetings.
- The daily safety briefing ensured all members of staff working that day were made aware of information about the safety of patients and the running of the unit for that day.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- The electronic recording system prompted medical staff to complete mental capacity assessments when patients were admitted. The practice of the ICU staff attending to the patient in the ED meant that a patient's capacity could be assessed before any urgent treatment or sedation was given. We saw electronic records showed that patient consent to intubation and ventilation was gained before this occurred, along with their consent to share information about their clinical condition with named family members.
- The senior nurse who had a lead role for rehabilitation also had the lead role for ensuring staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff, including nursing, medical and allied healthcare professionals, demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- There was a protocol to follow in the event of applying for Deprivation of Liberty Safeguards authorisations. Records showed that applications for Deprivation of Liberty Safeguards authorisations had been made appropriately to reduce the risk to a patient who had been trying to leave but did not have the capacity to understand the risks that this posed to them.

- Information was displayed in the junior doctor's office about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards for them to refer to.

Are critical care services caring?

Outstanding



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

We rated caring as outstanding.

Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback from patients and their relatives was continually positive about the way staff treated them. Patient and relative feedback strongly evidenced there was a caring and supportive culture in the critical care unit. Relatives commented that staff went the extra mile with nursing staff washing their parent's hair and moisturising their skin.

Patients and relatives were active partners in their care and treatment. Staff were fully committed to working in partnership with patients and relatives. Explanations of care and treatment were delivered to patients and their families in way they understood. Staff were always available to help patients and relatives understand explanations. Records were kept of discussions with relatives and patients so staff could ensure information was not conflicting.

Relationships between people who use the service, those close to them and staff were strong, caring and supportive. We observed staff attending to a patient's relative who had become unwell with compassion and empathy

Patient's emotional needs were highly valued by staff and were embedded in their care and treatment. Emotional support was available and provided whilst patients were on the unit. A follow up service provided opportunity for patients to discuss their experience in ICU and how it physically and psychologically affected them. Staff took the views of patients seriously and where possible changes were made to the service provision to reduce emotional stress for patients

Compassionate care

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- 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 with patients and their relatives in a caring and compassionate manner, providing reassurance and support.
- Comments from relatives repeatedly stated they could not fault the care their relative was receiving from all staff. One relative commented that staff had gone the extra mile, with nursing staff washing their parent's hair and moisturising their skin.
- One set of relatives, when expressing their positive view of the service, stated that if they could they would "tick every box".
- We observed pharmacy, nursing and medical staff attending to a patient's relative, who had become unwell due the shock of their family member being unwell, with compassion and empathy.

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.
- Patient diaries were kept for patients who were unconscious for over three days. These outlined what events had taken place whilst patients were unconscious. Relatives also made entries in the diaries. These helped patients fill in the missing gaps in their lives during their stay in critical care.
- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted overnight with any changes in their family member's condition and their wishes about this were respected.
- Both patients and their relatives commented that information was discussed in a manner they understood. They said there was always a member of staff available to help them understand the explanations. Relatives said staff explained everything to the patient, even though their understanding might be limited or not known.
- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce any anxiety. Patients and

relatives who we spoke with told us that staff on the unit were very supportive, and explanations about equipment and what was happening helped to reduce their anxiety.

- Records of conversations were detailed on the electronic recording system. This meant staff always knew what explanations had been provided and reduced the risk of confusing or conflicting information being given to relatives and patients.

Emotional support

- The unit offered follow-up clinics where patients were invited to return so their stay and care in the ICU could be explained to them to aid them with their emotional recovery. Feedback from these clinics had resulted in changes to care practices to reduce anxieties experienced by patients after discharge from the unit. This included asking patients about their experiences of hallucinations while they were a patient in the ICU, assessing what actions/noises in the unit could be contributing to causing the hallucinations and trying to eliminate some of those noises and actions.
- Staff said emotional support for patients and their families was available from the trust chaplaincy team, who provided support for patients of all faiths and those who did not have a faith.
- There were appropriate quiet areas and rooms to take relatives when discussing the patient's care or breaking bad news.
- Relatives expressed they felt they were getting good support from all staff working in the unit.
- Staff were able to access the 'self-harm' team to provide support for patients who had been admitted having self-harmed.

Are critical care services responsive?

Good



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

We rated responsive as good

Critical care services were responsive to the individual needs of their patients. Staff made reasonable adjustments, such as enabling parents and/or carers to stay and be involved in care for patients with a learning

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disability. The needs of patients living with dementia were considered. Training about dementia awareness was available, with a good uptake of this training by nursing staff. Relevant documentation, in line with national guidance, was used to help staff understand how patients living with dementia and a learning disability communicated and preferred their support and care to be delivered.

The pendant system in each bed space, into which equipment was plugged in, was fixed in a position half-way down the bed space rather than the usual two-thirds. This meant beds could be positioned at an angle so patients could see out of windows and into the unit if they wished, rather than only into the unit or only out of the window.

The service provided comprehensive information for patients and relatives in the form of leaflets and information on the unit's website. However, not all information was accessible for people who may have visual or reading problems.

Patient flow issues in the general hospital resulted in the unit performing worse than similar units for out of hours discharges from the unit. The unit recognised this was a risk to patients and had taken action to mitigate any risks.

To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the unit had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care retrieval team in the ED, before admission to the unit. This also happened for patients requiring admission to the unit from the general wards.

Staff understood how to manage complaints. Information was available for patients and relatives on the unit's and the trust's websites.

Service planning and delivery to meet the needs of local people

- The intensive care unit (ICU) was planned by the present team of senior medical and nursing staff taking into account the needs of the local population and the building guidelines as they were at that time (2001). Capacity was built in so that the service could expand in line with the predicted increase of the local population and healthcare needs.

- In response to increasing demand, the unit had recently commissioned a further five beds to increase capacity from 19 to 24 beds. At the time of building the adjoining respiratory ward was built to ICU specifications as a planned expansion of the unit, to increase the bed capacity to 36. The general manager and chief of service for the clinical service group said that present calculations indicated these beds will be required within a two- to three-year period.
- The general manager and chief of service said they worked with the local clinical commissioning group to ensure plans for the service met with the needs of the changing local population.

Meeting people's individual needs

- The unit responded to patients' individual needs. Information obtained in follow-up clinics for patients resulted in modifications being made to the unit and working practices with the view of addressing future patients' individual needs.
- Staff knew how to contact the learning disability nurses for support if a patient with a learning disability was admitted to the unit. We observed good care practices and reasonable adjustments being made to care for patient with a learning disability and to ensure their parents continued to be involved in the support and care of the patient. Hospital passports were used to provide guidance for staff about the support and care the patient needed.
- Training was provided for all staff about caring for patients living with dementia. Records showed that 92% of all nursing staff had completed this training. However, only 50% of medical staff had completed this training. It was noted that a recent intake of new junior medical staff had a negative impact on the numbers of medical staff that had completed this training. The education board displayed notices about forthcoming dementia training. The 'This is me' document was used for patients living with dementia. This is a tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.
- The unit was built in 2009 according to the building guidelines at that time. Clinical staff, both nursing and medical, had had input into the design of the unit. This resulted in all bed areas having windows to allow for natural light.
- Bed positioning on most critical care services was that they faced into the building. Some units demonstrated

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good practices where conscious patients could choose to have their bed positioned so they could look out of the window or look into the unit. Queen Alexandra Hospital's critical care unit had identified that although patients wanted the opportunity to look out of the window, some felt isolated and vulnerable because they could not see into the unit where most staff were. The pendant system in each bed space, into which equipment was plugged in, was fixed in a position half-way down the bed space rather than the usual two thirds. This meant beds could be positioned at an angle so patients could see out of windows and into the unit if they wished, rather than only into the unit or only out of the window.

- Staff reported there was 24-hour access to translation services.
- Information leaflets about what to expect in an intensive care unit were available to visitors in the waiting area. This included literature suitable for children. However, there was no literature in languages other than English and no details about how to access such information.
- Information about the critical care services was available on the trust website, which referred the reader to the unit's own website. The critical care website had comprehensive information about what to expect when visiting a patient on the unit and how to give feedback about the service, both positive and negative. There were links to other organisations that provided support and information to families and patients who experienced a critical illness, including to the Intensive Care Foundation, the Intensive Care Society and ICUSTeps. However the information on the website was not easily accessible to people who had any difficulties with reading. There was no process to enlarge the writing for people who had visual difficulties. There was no process to change the background colour for people with dyslexia. There was no process to translate the information. This meant that some people might not be able to fully access the information.

Access and flow

- Data provided by the trust showed that in the period May to September 2014 there were a total of 45 patient discharges that occurred out of hours (between 10pm and 7am). This did not meet the Core Standards for Intensive care 2013 guidance that details historically discharges from critical care services overnight have been associated with excess mortality and because

patients perceive it as extremely unpleasant being moved from critical care areas to a general ward outside of normal working hours. Intensive Care National Audit and Research Centre data confirmed that ICU discharges occurring out of hours were higher than those of similar intensive care units in the country.

- Data from the trust showed that delayed discharges (discharges made four hours after the decision to discharge) for the months May to September 2014 ranged from 17.8% to 56.77%. Intensive Care National Audit and Research Centre data showed that, for patients with timeliness of discharge reported as delayed, the unit performed worse than similar units. However for discharges with a delay of four hours or more between times when fully ready for discharge and time of discharge, the unit performed better than similar units.
- The prime reason for discharges being delayed was a lack of beds available on the general wards. The unit recognised this was a risk to patients and had taken action to mitigate any risks. This included developing a comprehensive discharge summary and ensuring patients were not discharged just before their required medicines.
- There was no clear data for delayed admissions to the unit. To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the unit had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care retrieval team in the ED, before admission to the unit. This also happened for patients requiring admission to the unit from the general wards.
- Delays in admissions and discharges had been flagged up by a peer review process. In response to the peer review the bed capacity of the unit had increased from 19 to 24 beds to meet the increased demand for critical care beds.
- Cancellation of surgery because of lack of critical care beds was infrequent. Records showed that for the period April to June 2014, only one surgical procedure was cancelled and for the period July to September 2014 two surgical procedures were cancelled.
- Some patients were discharged home directly from the unit. For some patients this was assessed as being the appropriate pathway. Patients admitted because of self-harm, for example patients who had taken an

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overdose, were referred to the self-harm team. If the self-harm team assessed the patient as physically fit to be discharged home with the support of the community self-harm team, this was done directly from the unit, rather than distressing the person with a move to a general ward. Some patients in high-risk categories admitted for planned surgery had a care pathway that included their two-day surgical recovery period being treated on the critical care unit to monitor for adverse effects of the surgery. Once this period was over they were discharged directly home by the planned pathway.

- Processes were in place to ensure patients who were discharged from the unit because of delayed discharges to the general wards were managed safely. This included the unit's pharmacist facilitating the patient's medicines to take home, and ensuring the base speciality took responsibility for the discharge process and letters.

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 a formal complaint. Information about complaints processes were displayed in the ward/unit areas. Staff had all been issued with a 'complaints handling guide for staff'.
- Patients and relatives said they would voice concerns or complaints directly to the nurse in charge of the shift or the nurse caring for them. They were confident that concerns and complaints would be treated seriously and dealt with promptly. Some relatives shared that they had raised some concerns that had been dealt with promptly and to their satisfaction. Information about who to raise concerns with and make a complaint to was detailed on the unit's website.

Are critical care services well-led?

Outstanding



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 outstanding.

The unit had a clear vision to provide an effective service that was able to support patients at all times. Forward thinking when planning the build of the unit meant there was opportunity to expand the unit as the demand for critical care services rose.

Governance processes promoted multidisciplinary reviews of the service provision and identified areas for improvement.

There was strong, supportive and effective leadership of the service. Staff were supported to develop leadership skills. The culture of leadership resulted in a no-blame culture, where lessons could be learnt from incidents and mistakes without blame being apportioned to staff.

There was clearly a strong team working culture on the unit, with all staff supporting each other. At times of intense clinical need, staff would work on the unit rather than complete their non-clinical duties. Consultants worked as registrars to cover medical vacancies; they reported there was no pressure to do this and commented they were doing it for the 'team'. All staff were listened to; no idea was ignored regardless of whether it was suggested by a healthcare support worker or a consultant.

The unit made use of social media to engage both with staff and the public. A Twitter account the unit's website enabled the unit to inform the public about the service provided. The website gave details and links about how patients and relatives could provide feedback. We saw patients and relatives used these for giving feedback about the service.

The views of patients and relatives were considered at follow-up appointments and changes made to the service provision where possible. This included responding to patients' experiences of hallucinations whilst a patient on the unit. Staff had considered what factors could contribute to the hallucinations and were trying to eliminate some of the noises and situations that appeared to lead to some of the hallucinations.

The unit made use of the trust's 'listening into action' programme to seek the views of staff about small changes that could be made to improve outcomes for both patients and staff. An example of one change was the planned introduction of a quiet rest time for patients.

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Innovative ideas and approaches to care were encouraged and supported, many of which were enhancing patient safety and experience on the unit. This included the practice of daily safety briefings to ensure the whole multidisciplinary team were aware of potential risks to patients and the running of the unit, and the development of an educational website that could be accessed by the public.

Vision and strategy for this service

- All staff described they were committed to an effective service that was able to support patients at all times. This mirrored the statement on their website “We are focussed on providing an excellent service, compassionate and high quality patient care and support for both our patients and their family.”
- The leadership of the service had been forward looking when planning the build of the unit in 2009. They had considered the increasing demand for critical care services and had designed the unit so the adjoining respiratory ward was built to intensive care unit (ICU) specifications as a planned expansion of the unit, to increase the bed capacity to 36.
- The unit’s IT team were working with the vision to continually use and improve the IT systems to benefit patient care, treatment and experience.

Governance, risk management and quality measurement

- Governance meetings for the critical care, hospital sterilisation and decontamination unit, departments of anaesthesia, infection prevention/control and theatre care service group were attended by representatives of the critical care unit. 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 critical care services, education, HR issues and clinical effectiveness were considered at these meetings. Updates from actions taken following previous meetings were discussed.
- There was a lead consultant for governance, as well as a staff group with responsibility for governance of the unit.
- Peer reviews of the service had been completed by the regional critical care network. Records from these peer reviews showed that areas identified as requiring improvements as part of the peer reviews were acted on.

- The unit took part in national surveys to monitor the effectiveness of the service. There was a local audit plan that included small audit projects and larger national and local audit projects.
- Patients and relatives were involved in the governance process giving their views about their experiences in satisfaction surveys and at follow-up clinics.
- The trust’s corporate risk register did not have any items detailed on it that related to critical care services. The critical care risk register clearly detailed risks to the service and action being taken to mitigate these risks. Escalation processes were followed if the unit was not able to act on the risks themselves. We saw evidence that risks associated with delayed and out of hours discharges had been escalated to the trust.
- The matron told us that monthly performance reviews were completed and presented to the senior management team. These included data about compliance with hand hygiene practices, Intensive Care National Audit and Research Centre data and incident alerts.
- The matron said the unit was researching performance indicators that were more relevant to the critical care setting, so the service could be monitored more accurately.

Leadership of service

- Staff spoke highly about and had confidence in their leaders (matrons, senior sisters and consultants).
- Staff felt the leadership of the service promoted a ‘no blame’ culture, where all staff could learn from mistakes.
- Staff said there was always a supernumerary coordinator and a band seven sister on duty on each side of the unit. This made them feel well supported to provide safe and appropriate care for patients.
- To address the lack of progression for junior staff, senior band five progression days had been implemented by the unit, which supported nurses to develop their management skills. Senior staff had identified the stable senior workforce meant there was little opportunity for junior staff to develop leadership skills. To address this issue there was a plan to have one nurse leading a team of three other nurses in caring for a group of four patients in order to support staff in developing leadership skills.
- The unit had many clinical groups that included nursing and medical membership. This included a pharmacy group, infection control group, governance,

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safeguarding, paediatric, IT, rehabilitation and equipment groups. Each of these groups had a leader, who could be a nurse of any grade or a member of the medical staff of any grade.

- We were told by the general manager that the Clinical Service Centre did not have a cost improvement plan; they said this was because they had demonstrated in previous years they could manage their budget and make appropriate savings. They felt very proud and privileged that they had managed to meet all their previous cost improvement plans and quality targets.

Culture within the service

- Staff spoke positively about the service they provided for patients. They said there was an open and transparent culture that focused on meeting patient needs.
- Safety briefings demonstrated a culture of 'no blame', rather learning from mistakes and near misses to see how they could do better next time. There was no focus on any individual blame/error.
- 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.
- Consultants said they were very happy to work on the unit. They described their colleagues as being enthusiastic and flexible. Medical staff were encouraged to develop specific clinical interests.
- It was evident that all staff supported each other. At times of intense clinical need, staff would work on the unit rather than complete their non-clinical duties. This included outreach nursing staff, nurse educators and senior nursing staff who had administrative duties working on the unit at times of extreme clinical activity. Medical staff responded in the same way, with consultants who were on supporting professional activity time (part of a medical job description that is distinct from direct clinical care) assisting on the unit during periods of extreme activity.
- There was a strong ethos of team work. This was demonstrated by consultants working as registrars to cover vacancies. They reported there was no pressure to do this and commented they were doing it for the 'team'.

- Other examples of the unit working as a team included at the consultants meeting discussions being held about social events that included nurses and allied healthcare professionals, demonstrating there was no division between the differing roles.
- Staff said that all staff were listened to and no idea was ignored regardless of whether it was suggested by a healthcare support worker or a consultant.
- There was a caring culture towards staff on the unit. We observed the clinical lead, at the end of a safety briefing, praising all staff for coping with the previous day, which had been busy and distressing. We saw records of staff meetings that clearly stated that if a member of staff had a personal crisis that necessitated them having to leave work, they must be allowed to do this and the type of leave it was would be discussed at a later date. The matron described how she had consulted with the occupational health department when a number of staff members were experiencing a similar illness. She had concerns that the working environment might have been making staff ill.

Public and staff engagement

- Information was shared with the team. A monthly newsletter was emailed to all staff which included information about performance, incidents and other items. This was also available on the trust's intranet.
- The trust a 'listening into action' initiative. This was a programme to seek the views and opinions of staff about small changes that could be made to working practice to improve outcomes for patients and working practices for staff. The critical care unit had held a listening into action event and were in the process of implementing some of the suggested changes. This included introducing a quiet rest time for patients and the plan to have one nurse leading a team of three other nurses in caring for a group of four patients in order to support staff in developing leadership skills.
- The unit had secure Twitter and Facebook accounts so staff could send and receive communications.
- The matron said they had previously held road shows for GPs to enable them to understand the work of the critical care unit and they were considering holding more events.
- Patient and family feedback was obtained by the use of satisfaction surveys and during follow-up

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appointments. The unit's website gave details and links about how patients and relatives could provide feedback. We saw that patients used these for giving feedback about the service.

Innovation, improvement and sustainability

- The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service.
- The practice of daily safety briefings on the unit ensured the whole multidisciplinary team were aware of potential risks to patients and the running of the unit.
- There were continual and innovative approaches to the development and use of IT systems and social media. Secure Facebook and Twitter accounts enabled staff to be updated about events affecting the running of the service. This included information about risks, potential risks and incidents. Electronic 'Watch out' screens in the unit displayed information about incidents and the unit's risk register.
- The education team advertised information about training opportunities on the education Twitter account.
- Innovative electronic recording systems supported the effective assessment and monitoring of patients.
- Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.
- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled the outreach team to view the monitoring of patients on all wards.
- In most critical care services, beds are positioned to face into the ward. On some units beds were positioned so that conscious patients could look out of window. Queen Alexandra Hospital's critical care unit had learnt that some patients were frightened when they could not see the ward and wanted to be able to see into unit for reassurance. In response, the positioning of the pendant system that equipment was plugged into meant beds could be positioned at an angle so patients could see out of windows as well as into the unit.
- In response to difficulties recruiting middle-grade (registrar) doctors, the unit in partnership with the University of Portsmouth was developing a two-year course in Advanced Critical Care Practice (ACCP). It was envisaged the advanced critical care practitioners would relieve medical staff of routine medical duties allowing them to attend to the more intricate medical roles. It was planned that this training, the entry criteria for which is the first of its kind, would commence in autumn 2015.
- To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the unit had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care team that included medical and nursing staff in the ED, before admission to the unit. The same practice was followed for patients requiring admission to the unit from the general wards.
- The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.
- The critical care unit had developed their own innovative website that included educational information and guidance documents. There was guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.

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Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

The hospital provides maternity and gynaecology services to a local population of approximately 650,000 people who live in Portsmouth city centre and the surrounding areas. Maternity services are also provided at community maternity centres (midwife-led units) located at Petersfield, Gosport and Portsmouth. There were 5,966 births within the service between 1 April 2013 and 31 March 2014. This put the hospital in the top 25% of numbers of births in health services in England.

Obstetric and specialist clinics are run by consultants and specialist midwives across the area. For example, a specific diabetes clinic. Antenatal clinics were held Monday to Friday at the main hospital site and also in community settings including the birth centres and children's centres.

During the inspection we visited the consultant-led obstetric unit, the midwife-led co-located birthing unit at the hospital, maternity outpatients, the day assessment unit and the midwife-led birthing units at Gosport and Portsmouth.

Gynaecological services are provided at the hospital on a 22-bedded ward of which 16 are specifically for gynaecological patients, and within the outpatient department, the early pregnancy assessment unit and the emergency gynaecological assessment unit. During the inspection we visited the ward and outpatients areas.

We spoke with 32 patients, two relatives and 53 members of staff to seek their views of the services provided and/or experienced. The staff we spoke with included senior

managers, midwives, specialist midwives, supervisors of midwives, maternity support workers, ward clerks, housekeepers, administrators, nurses, specialist nurses, consultants, anaesthetists and junior doctors.

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Summary of findings

Patients who used the maternity and gynaecology services were protected from avoidable harm.

The trust took action in response to reported incidents and feedback was provided to staff to ensure learning from previous incidents was achieved. When something went wrong there was an investigation, carried out by appropriate staff. Patients were included in discussions and feedback about their care.

Systems and processes were in place to promote the control of infection and ensure equipment in use was safe by servicing, maintenance and keeping it clean. Safeguarding women and babies was given high priority by the staff who were proactive in identifying and liaising with a multidisciplinary team to ensure the involvement of appropriate staff.

Systems were in place to review staffing levels to ensure they were safe. The staffing levels and skill mix on both the consultant-led obstetric unit and the gynaecology ward was discussed at handover and arrangements were made, if necessary, to risk assess and manage the staffing of each area. The consultant presence on the consultant-led obstetric unit had been measured against guidelines in Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007). As the level of cover was lower than that recommended, this had been placed on the risk register and a business plan was being developed to obtain increased consultant cover. The safety of women was promoted by consultants attending the unit over the weekends in their on-call rota time.

The care and treatment provided to patients was effective in that patients experienced care, treatment and support that provided good outcomes for them.

The integrated model which the trust maternity service runs (Nurture programme) allowed flexible use of staff to maintain 1:1 care in labour. This had kept women's denied choice of place of birth to a minimum. However, the access and flow of women through the maternity unit had affected where staff were required to work and on rare occasions affected the choices women could make on where they delivered their baby. Because of pressures on medical beds, some medical patients were

transferred to the gynaecology ward, which had increased the numbers of cancelled gynaecology operations. An action plan was in place to reduce the waiting time for women whose operation had previously been cancelled.

Patients' care and treatment was provided in line with current evidenced-based guidance, national recommendations and legislation. Care and treatment was updated following changes in best practice guidance and legislation. The trust monitored the care and treatment provided to women; the data showed women received an effective service when compared with women in other parts of England.

Patients received an outstanding caring service because staff involved and treated patients with compassion, kindness, dignity and respect. Relationships between the staff and patients were strong, caring and trusting. Patients and their representatives were encouraged to make choices and were involved in their care and treatment. Staff took patients personal, cultural, social and religious needs into account when providing care and treatment.

Patients were actively encouraged to complete quality monitoring surveys and participated in the national NHS Friends and Family Test quality surveys, from which positive responses had been received.

Patients received a responsive service because the service provided was organised to meet the needs of women in their local areas. For example, antenatal and postnatal clinics and the midwife-led birthing units. Additional gynaecology clinics and appropriately trained staff had been put in place to meet the increased demand of newly referred patients. Women were informed on how to make a complaint and complaints were acted on and monitored effectively by the women's and children governance and quality committee.

The service was well led because the leadership, management and governance of the organisation assured the delivery of high-quality person-centred care and promoted an open and fair culture.

Staff were positive about the management of their services and the accessibility to their line and senior managers. Innovative practice was encouraged and in

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evidence within the trust, including the development of an application to be used on smart phones and tablets enabling women to access information to make choices and decisions regarding their birth. Student midwives had support from experienced community midwives to run a postnatal clinic to increase their knowledge and competencies.

Are maternity and gynaecology services safe?

Good



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

We rated safe as good.

Staff reported incidents and learning was shared; practice changed as a result. Staff were aware of the duty of candour legislation, which is about being open and transparent when things go wrong. Patients were informed and received feedback about their care. Staff were supported to identify and support women and babies at risk. Risk assessments were undertaken and actions put in place to reduce the likelihood of risks occurring. Processes to safeguard women and children were followed.

Infection prevention and control measures were followed and the clinical areas we visited were visibly clean and tidy. There were two dedicated obstetric theatres for elective and emergency care for women. Appropriate equipment was available and there were systems in place to ensure the safe maintenance and servicing of equipment. Some emergency equipment on the gynaecology ward had not had regular checks. Medicines were stored securely and administered correctly, although some prescribed medicines had not been given to women.

Midwife staffing levels were below the England average and national recommendations. However, staffed worked flexibly to provide one-to-one care for women in labour. Staffing levels were reviewed at each shift change and escalation procedures were followed if there were any staffing concerns. The trust reported 69.5 hours dedicated consultant cover on the delivery suite, which fell below the recommended 98-hour consultant presence to meet the recommendations of RCOG Safer Childbirth (2007) with a consultant led birth rate of 4,522. However, medical staff worked flexibly and consultant cover and senior medical staff cover was higher than the England average.

Patients' confidential and personal information contained in care and treatment records was not consistently stored securely on the gynaecology ward. Records to reflect the care patients had received were not consistently completed.

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Incidents

- The staff reported incidents through an electronic reporting system. Staff we spoke with were aware of the process to follow to make a report and gave examples of when they would do so. Newly appointed staff were provided with guidance about the incident reporting system during their induction. Newly qualified midwives were provided with support through their preceptorship by the practice educator on reporting incidents.
- Staff informed us that they were provided with guidance on incident categories to report and said a trigger list was being well used. This served as a reminder to ensure all appropriate incidents were reported.
- We reviewed incidents previously reported to the trust before our inspection, together with the action that had been taken to address the situation. Incidents reported included staffing concerns, equipment concerns, post-partum haemorrhages and third- and fourth-degree tears. Staff told us they received feedback on reports they had made.
- Serious incidents were investigated by the trust and the relevant reports from these investigations were reviewed and discussed at the gynaecology clinical governance meetings and the maternity quality and management forum. Minutes of these minutes showed actions were followed up and learning taken from the investigation to improve the future service provided. We saw action had been taken to improve the visual information about the emergency call sign staff would use to summons the resuscitation team if a patient became seriously unwell. Further guidance and training was provided in annual mandatory training for midwives. We also saw changes to paperwork had been made for gynaecology patients and an investigations stamp was in use in patient records on the maternity unit following reported incidents.
- The trust reviewed reported incidents during governance meetings. For example, as part of the women and children's clinical service centre, governance and quality committee meeting was held monthly and attended by senior management staff. Incidents had been included and reviewed to ensure appropriate action had been taken and also to identify any themes or patterns that emerged from clinical areas.
- A report from the women's and children's clinical service centre was presented quarterly to the trust's governance

and quality committee to ensure incidents and concerns were raised at board level. Incidents that had been rated as high risk were included in this report, together with a summary and the action taken following the incident.

- Lessons learned from incidents and changes to practice were shared with staff. We were given an example of how documentation had been reviewed and developed to ensure clear reporting following a previous incident. Additional guidance had been given to staff about the cleaning of equipment following use after dirty equipment had been identified and reported during routine checks.
- Monthly multidisciplinary perinatal meetings were attended by obstetricians, midwives and neonatologists. At these meetings individual mortality and morbidity cases were discussed. Minutes of these meetings were recorded and showed actions that were to be taken regarding any specific cases and who was responsible to lead on the action.
- The hospital contributed to MBRRACE-UK (Mothers and babies: reducing risk through audits and confidential enquiries across the UK). The aim of this national programme is to provide robust information to support the delivery of safe, equitable, high-quality patient-centred maternal new-born and infant health services. The trust provided appropriate information to MBRRACE – UK, which then reviewed maternal deaths, stillbirths and infant deaths. An action plan was in place following the MBRRACE report published in December 2014.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS
- We spoke with staff throughout our inspection who were aware of the principles of duty of candour and told us that these principles had been in place within the trust before the new legislation came into effect. Staff

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were positive about the introduction of the legislation and one person stated it would formalise “what we have always done”. Medical staff reported training had been provided to them and duty of candour was regularly discussed at team meetings.

- The trust’s electronic reporting system had been amended to include a reminder regarding duty of candour when reporting an incident.
- Noticeboards on the wards provided information for patients, visitors and staff regarding the duty of candour.
- Patients were offered the opportunity for a debriefing meeting following any reported incident. Examples were given by staff regarding positive meeting experiences for patient that enabled women to express themselves and give their views as well as receiving information regarding the incident from the trust.
- Written responses to duty of candour issues were evidenced. We saw a tracking system was in place to link the written response to the original incident report to enable the trust to identify any themes or patterns.

Safety Thermometer

- The maternity and gynaecology wards gathered information in order to participate in the NHS Safety Thermometer. Information collected related to pressure ulcers, falls with harm, catheters and urinary tract infections, and venous thromboembolism. The clinical scorecard showed that nine months had been harm-free. There had been two incidents of venous thromboembolism and one catheter-related urinary tract infection. The gynaecology Safety Thermometer outcomes were discussed at the gynaecology clinical governance meetings and trends identified.
- Women admitted to the maternity and gynaecology wards were assessed on admission for risks relating to venous thromboembolism. The Safety Thermometer for the gynaecology wards showed there had been no venous thromboembolisms for patients from January 2014 to January 2015. The maternity services recorded information on the maternity clinical scorecard, which showed 3% of women had not been risk assessed. This had been followed up and reminders given to staff at handovers.
- The maternity and gynaecology wards also used a visual reminder known as the calendar crosses to demonstrate the safety of patient care on the wards. The monthly calendar cross identified, at a glance, any issues with staffing levels, medication errors and patient cannula

site checks. We found that the individual patient records had been maintained to show the care provided to patients regarding their cannula and cannula site. However, the calendar cross had not been consistently completed to reflect this care had been provided. This could lead to a false impression of safety and care on the ward to visitors and patients. Staff told us that when the wards were busy the calendar crosses were not always completed. We saw reminders were provided to staff at handover from the bleep holder’s notes and records regarding completion of the crosses.

Cleanliness, infection control and hygiene

- The CQC carried out a national survey in 2013 of women’s experiences of maternity services. The outcomes showed that the trust was rated about the same as other trusts for cleanliness when they were in hospital.
- Housekeeping staff were clear about the planned cleaning schedules in place and which tasks were undertaken on a daily, weekly, monthly or six-monthly basis. The clinical areas we visited were visibly clean. Audits were completed regarding specific cleaning tasks. The theatre cleaning audit from August 2014 showed high standards had been achieved. Hand hygiene audits showed 100% compliance with the policies and procedures in place, with the results displayed in the wards.
- Procedures were in place for cleaning birthing pools after use and each day, which ensured they were fit for use. Equipment appeared clean and ready for use on the maternity and gynaecology wards and we saw staff cleaning equipment after use. There were stickers that identified equipment was clean and ready to use in some areas, but these were not used consistently. Staff on the gynaecology ward told us they maintained a book that identified when equipment had been cleaned. However, during our inspection we later saw stickers used on equipment in the ward.
- Information regarding hand washing and the use of antibacterial gel was in place in clinical areas and for patients and visitors to see. Doors at the entrance to wards had gel dispensers on the handle so that the hands of visitors entering the ward were sanitised. We saw staff washed their hands regularly and between providing care to patients.

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- Personal and protective equipment was available in plentiful supplies and used appropriately. Staff adhered to a 'bare below the elbows' policy in clinical areas to promote the control of infection, with the exception of one clerical worker on the gynaecology ward.
- Infection control issues were discussed in detail by medical and nursing staff at handover. For example, the care of one pregnant woman with an infectious respiratory illness. The discussion included actions staff needed to take regarding the patient's care and treatment and their own protection from the infection.

Environment and equipment

- Resuscitation equipment was available on all wards and departments. Staff were required to check emergency trolleys and oxygen and suction daily to ensure these were ready for use. In the previous six weeks, records showed the resuscitation trolley in the gynaecology outpatients department had not been checked on six occasions and the trolley on the gynaecology ward had been missed on four days. On the day of our inspections the trolleys were checked and signed as being ready for use.
- Emergency equipment was available for the management of post-partum haemorrhage in all birthing areas.
- Foetal cardiotochograph machines were located throughout the labour, antenatal and induction wards, which were on a programme of replacement, with some machines still requiring replacement.
- The community midwives had access to home birthing boxes, which were checked, dated and resealed after use.
- The acute unit had overhead hoists and portable hoists if needed for assisting a woman out of the birthing pool in an emergency. The community centres had a net available for use in an emergency in each room with a birthing pool.
- The midwifery unit employed two equipment officers to manage and ensure equipment was fit for use. Any faulty equipment was placed in a designated area and labelled to identify the fault. The equipment officers checked daily for any repairs required and either actioned this themselves or arranged for the equipment to be sent to the medical electronics department for repair. We saw staff discussed equipment issues with the officers on the wards. Staff made positive comments about the service provided and gave an example of

when a resuscitaire had been discovered to be faulty and how it had been repaired immediately. Equipment used in the community settings was repaired and serviced by the medical electronics department.

- The equipment on the labour and postnatal wards was required to be checked at varying intervals, for example, daily, weekly, monthly, six-monthly or annually, depending on the manufacturer's guidelines and risk assessment. There was a clear system in place to identify the frequency of checking and servicing, with records showing when this had been completed.
- A list of all equipment, including the serial number, purchase date, location and date of last check, was maintained by the medical electronics department electronically.
- Security in the maternity wards was maintained with locked doors that were monitored using CCTV. The clinical staff advised reception staff when women were expected to arrive on the ward and who was being discharged, to provide additional security.
- The obstetrics teams had access to two designated theatres. An entry had been made on the risk register in October 2014 that identified the flooring in theatre required replacement. Plans were being made to ensure safety and access to appropriate theatre provision while the work was undertaken. No date had been fixed for the repair work at the time of our inspection.
- Bariatric equipment was available in the hospital, for example a wheelchair and access to beds if required.

Medicines

- We found medicines were stored securely in the gynaecology and maternity clinical areas and wards. Records were maintained showing fridge temperatures were checked to ensure medication was stored at the correct temperature.
- Patients' medication was prescribed on individual medication records. We noted that two patients on the gynaecology ward had not had their medication administered as prescribed. One patient's records showed medication had not been given on two occasions but did not give a reason why. Another record identified the patient's medication had been out of stock for two days, meaning they had missed four doses. There was no information recorded to show any action had been taken to address this.

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- Patients' medication charts clearly identified any known allergies to reduce the risk of being given inappropriate medication.
- We observed staff administering medication on two different wards. We saw this was carried out in a safe way.
- Controlled drugs were stored, administered and recorded safely in the gynaecology and midwifery wards and community birthing centres. The midwife in charge checked the controlled drugs balances with the midwife taking over from them at the end and beginning of the shift.

Records

- Women carried their own records for the duration of their pregnancy. We saw women attended clinics and ward areas with their records, which staff then reviewed and completed appropriately.
- Once on the wards, or in the community birthing units, the staff took responsibility for the records. We saw records left unsecured and unattended at nursing stations. This also was identified on the gynaecology ward and assessment unit. This did not ensure the security of patients' confidential and personal information.
- Postnatal women and babies were provided with postnatal notes, which they took with them on discharge. These were reviewed and updated by community midwifery staff at subsequent visits.
- The records for patients admitted to the gynaecology ward contained care plan documentation that identified their care and treatment while on the ward. Staff maintained and updated these as appropriate. There were two systems of recording in place on the gynaecology ward, an electronic and paper record. Review of records identified there was no clear system of when a paper or electronic record was used, which caused a risk of information being missed and not recorded. For example, we saw nutritional risk assessments recorded for one patient on an electronic template and for another on a paper template. Intentional rounding or comfort rounds (a system of planned interaction and delivery of care for patients) information was recorded, but charts we inspected showed some gaps that indicated patients' personal care had not been delivered for several hours at a time. We discussed this with staff, who assured us this was a recording issue and not a result of lack of care. One

person's fluid chart had also not been completed for a period of six hours and another did not identify any urine output for a day. Again staff were confident these had been recording errors.

- Risk assessments were completed for patients as required and were individualised, such as on falls, moving and handling, nutrition, pressure damage risk and venous thromboembolism. Some records identified potential risks at a glance, for example using stickers and colour-coded paperwork to clearly identify where there were child protection issues.
- Personal information was displayed on the wards on large white boards. Women were asked to consent for their information to be included on the board and this consent was identified by a stamp included in their records. Not all women consented to their information being written on the board and this was clearly reflected in their notes.
- Ward clerks and administration staff worked from 8am until 8pm to assist with the management of admission and discharge records. Before discharge, checks were made to ensure the correct discharge address was noted before passing the information on to the community midwives.
- Appropriate information was completed by medical staff as required by the Department of Health regarding medical terminations of pregnancy. The information was collated and checked by the foetal medicine specialist midwife before returning the information.

Safeguarding

- Policies and procedures were in place for staff to follow regarding safeguarding vulnerable adults and child protection measures the hospital had put in place. Staff had received training in safeguarding and recognising abuse and were provided with an annual update as part of the mandatory training programme. Additional training was available for staff to attend regarding the recognition of domestic violence.
- Staff we spoke with were aware of the processes to follow and knew who the named safeguarding leads were with whom they could discuss concerns.
- The antenatal referral pathway in operation required GPs to refer patients online. The referral form prompted the GP to identify any current or previous safeguarding concerns.
- Safeguarding and child protection issues were discussed at handovers with both medical and nursing

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staff and assurances were sought that the appropriate people were aware of any issues. We observed at one handover that the medical staff ensured the nursing staff knew of a specific safeguarding issue and that the information had been clearly identified to the ward the woman was to be discharged to.

- Records relating to safeguarding concerns were printed on a different colour paper. This system had been implemented following learning from a previously reported incident, to ensure that the documentation was easily recognisable to all staff.
- An electronic safeguarding spreadsheet had been set up to ensure awareness of and attendance at all safeguarding meetings by an appropriate health professional. This was as a result of previous concerns that the required staff had not been informed of or attended safeguarding meetings. The member of staff who attended was not always the patient's named midwife but a handover was arranged before the meeting to ensure relevant information was passed on.
- Midwives had recorded an increase of female genital mutilation in women delivering their babies within the service. Advice and information was available for the women. When the women delivered a female baby, a referral was made to social services safeguarding department to highlight the risk.
- The Local Supervising Authority Midwifery officers provided information to the Nursing and Midwifery Council regarding how patients were safeguarded through maternity services. The report for 2011/12 identified actions had been taken to safeguard women.

Mandatory training

- All newly appointed staff were required to complete a period of induction training. Detailed records of the content of induction training were available for each role. Team leaders and practice educators held a record of the progress of new staff through their induction training and provided support to them.
- Staff were required to complete the trust's mandatory training. In addition to this, all midwives were required to attend Practical Obstetric Multi-Professional **Training (PROMPT)** annually. This training had a classroom theory component and workshops that provided the staff with an opportunity to take part in skills drills training in obstetric emergencies, such as shoulder dystocia, maternal collapse and newborn life support.

- The annual mandatory training and PROMPT were recorded on an electronic spreadsheet to identify which staff had attended and individual training records were available for inspection. We sampled five records of staff who were on duty during our inspection and found these members of staff were all up to date with their training.

Assessing and responding to patient risk

- Observations of patients' vital signs were recorded by staff and early warning scores alerted staff to a patient's health deteriorating. For maternity patients the modified early obstetric warning system was used to enable staff to escalate a patient who had become unwell or whose health was deteriorating.
- For women who were pregnant and unwell, there was the facility to receive care and treatment in the assessment and observation unit. This was a two-bedded side ward where women would receive 1:1 care. We were informed that recently qualified midwives received training on the identification and management of the critically ill patient and acute medical emergencies during their midwifery training. Staff told us that training was available from the trust, known as the Alert Course, and had been provided to some midwives to enable them to care for pregnant women with additional medical conditions effectively. However, insufficient staff had received this training to ensure there was always a member of staff on duty who had received this additional training. Action had been taken to address this by accessing additional training, and intensive therapy unit outreach support had been sought.
- Handover between nursing and medical staff alerted the oncoming shift to any patients whose health was a concern or who had deteriorated during the shift.
- There was always a senior nurse on duty who held a bleep. This member of staff was able to provide guidance and advice to patients, community midwives and GPs regarding the need for admission, either over the telephone or by advising the women to come to the acute unit to be assessed. Women made positive comments about this service and said they had been reassured by speaking with the midwife.
- The emergency gynaecology assessment unit received referrals from GPs and provided a 24-hour seven days a

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week service for patients who were experiencing gynaecological emergencies. Patients could be referred directly to this unit rather than having to be admitted through the emergency department.

Midwifery staffing

- A nationally recognised midwifery workforce planning tool, Birth rate plus, was used each year to review the staffing levels in the maternity unit. Previously a desktop review had been carried out, but we were told by senior managers that a full audit to monitor staffing levels was planned from March 2015. The managers informed us staffing was within limits set, but at times there had been challenges because the complexity of the care needs of mothers and babies had increased. Birth rate plus may show any increase in staffing levels required to support vulnerable families.
- Information about the assessed staffing levels was provided to the trust board each month and a maternity dashboard provided evidence of the staffing.
- The midwife to birth ratio was an average of 1:29, which was in line with the England average. The maternity dashboard clinical scorecard showed that the ratio had varied from 1:27 to 1:33 over the past 10 months. This reflected the actual number of midwives to birth and did not include maternity support workers. The Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) states there should be an average midwife to birth ratio of 1:28.
- A review of staffing had taken place and additional midwife support workers had been appointed to mitigate the midwife to birth ratio. The additional midwife support workers provided extra support to the midwives, particularly within the community setting and on the postnatal wards. Midwives who worked in the obstetric theatres were not included in the ratios, which enabled staff on the labour ward to ensure 1:1 care was provided to women in established labour.
- The staffing establishment for the acute unit was set to be 16 midwives during the day and 14 at night. The staffing rota was maintained electronically and inspection of the rota with a senior midwife, who explained the system to us, indicated that during one week in the month before our inspection, the staffing establishment had not been achieved every day. However, staff were moved within the unit and throughout the community to provide care and treatment where it had been identified additional staff were required. Monitoring of the staffing on the labour ward showed that women in established labour received 1:1 care.
- Each day a senior midwife managed the unit and part of this role was to review the staffing levels. Additional staff were brought in when required, including unit midwives who wished to work overtime or as bank staff. At times, midwives worked in other roles, such as specialist midwives, practice educators and community midwives. At times of extreme pressure on staffing, senior management, who were also practising midwives, assisted with clinical support on the wards. We saw records (a daily management recording sheet known internally as the 'bleep' sheet) that identified these measures. However, the bleep sheet did not consistently show movement of staff within the unit. This was acknowledged by managers and we have been told action has been taken to improve this record since our inspection.
- The trust had an escalation policy that clearly set out a colour-coded risk proforma detailing the action to take to ensure staffing levels were safe. Actions included closing peripheral midwife-led birthing units and bringing in community midwives to the acute unit. Staff we spoke with said the ultimate decision to suspend maternity services, because of unsafe staffing levels, had never been necessary as the situation had always been managed.
- The escalation plan had been activated the day before and during our inspection. This had resulted in moving a midwife from the postnatal ward to support staff on the labour ward. The postnatal ward had been left with two midwives and two maternity support workers to provide care for 12 mothers and babies, which was considered to be safe. We also saw that the antenatal ward was closed on one day of our inspection, which had meant four women were moved to the postnatal ward for their care and treatment. We spoke with one woman who had no concerns regarding this move. The closure of antenatal meant that the staff were able to assist on the labour ward, which had become busy.
- We spoke with 18 midwives and eight senior managers. All acknowledged that the unit was busy, with periods of higher activity at times. Midwives told us they considered the service to be safe and that appropriate action was taken to ensure additional staffing was in

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place when needed. Several of the midwives we spoke with referred to this as 'juggling' of staff and there was a constant need to reorganise staff on a daily or more frequent basis to ensure women and babies received appropriate care.

- There were seven vacancies for midwives across the unit and recruitment for these posts was underway.
- There was administration support in the form of ward clerks and reception staff who worked in the acute unit from 8am to 8pm to support the midwives with obtaining and preparing records and completing discharge administration tasks. This enabled midwives to continue with clinical care instead of dealing with paperwork.
- Detailed handovers between midwifery staff took place twice a day and staffing issues were discussed at these meetings in relation to the clinical requirements on the unit.
- The gynaecology ward operated a duty rota that met the establishment staffing levels. Staff told us at times the unit could be busy because an additional four beds could be opened, although they were able to obtain additional staff to manage this. We were informed these beds were often opened to accommodate outliers (patients whose medical and nursing care needs were for a speciality other than gynaecology) from other areas in the hospital. During our inspection we saw there were four patients from other areas. Additional funding had been secured for the staffing of these four beds.

Medical staffing

- There were eight consultant obstetricians in post who provided care and treatment within the acute unit and also managed clinics in the local communities, such as Petersfield, Fareham, Gosport, Waterlooville, Havant and Portsmouth.
- The maternity clinical scorecard showed that from April 2014 to January 2015 there had been 4,861 deliveries within the service. Predicted births for February and March 2015 estimated the service would deliver a total of 5,998 births in the year. Births within the obstetric led unit were predicted at 4,522. The Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance identified that when births reached between 4,000 and 5,000, 98 hours of consultant cover was recommended. Currently the trust provided 69.5 hours of consultant presence. This had

been identified as an issue on the risk register in July 2014 with an action to create a business plan for increased consultant cover. The service had a business plan to increase consultant hours to 98 to meet the recommendations. Consultants provided a presence on the ward at the weekends outside of the hours contracted and in addition to their emergency on-call and out-of-hours cover.

- The need for an additional consultant for the emergency gynaecology assessment unit had been recognised and approved by the trust. This position was due to be advertised.
- Data provided showed that the medical skill mix within obstetrics provided 3% higher consultant cover than the England average and that specialist registrar cover was 5% higher.
- Anaesthetist cover was available and during the day there were anaesthetists allocated to the elective surgery list and additional cover for emergency surgery and pain relief for women in labour. Anaesthetic support was available at night, which was separate to the trust's main surgical rota. This ensured women received treatment promptly.
- There were separate on-call consultant rotas for obstetrics and gynaecology care supported by appropriate grades of medical staff. This ensured women received treatment promptly.
- The gynaecology consultants provided 24-hour cover to the ward, with a ward round carried out each day. A rota identified appropriate grades of medical staff were in place to provide care and treatment to women on the gynaecology wards.
- Handovers took place during the day for doctors on both obstetrics and gynaecology. At the handover the staffing allocations were discussed, locums introduced to the team and a case summary of all patients, including expected admissions, were provided. We attended the evening handover during our inspection and saw that the medical teams carried out a detailed and informative information-sharing session.

Major incident awareness and training

- The trust-wide major incident policy was available to staff on the intranet. Staff were aware of how to access policies and procedures and were able to locate relevant policies and procedures quickly when asked.

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- The maternity services had an escalation policy regarding safe staffing that staff were aware of and gave examples of when this had been used.

Are maternity and gynaecology 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 rate effective as good.

Care and treatment was provided in line with evidence-based guidance and national guidance. There were good outcomes for patients. Staff encouraged normal births and the caesarean section rate was below the England average. Policies and procedures were monitored and reviewed and developed to reflect changes in national guidance and best practice recommendations.

Women who used the service had access to pain relief, which was discussed with them and administered appropriately.

Ongoing training was in place for midwives, midwife support workers and qualified nurses to ensure they were competent to carry out their roles. The supervisor of midwives to midwives ratio was 1:15, equal to the recommended ratio. There was good supportive multidisciplinary team working.

Consent processes were undertaken appropriately, with support available in the event of a concern regarding a woman's capacity to make decisions.

Evidence-based care and treatment

- Policies, procedures and guidance were available to staff on the trust's intranet. Staff we spoke with told us they found them easy to locate when required and two members of staff demonstrated their accessibility. Some guidelines had a review date of December 2014 but were in the process of being reviewed at the time of our inspection.
- Policies and procedures were developed in line with National Institute for Health and Care Excellence (NICE)

guidance. For example, the intrapartum guidelines for staff were reviewed and updated following publication of NICE's Intrapartum care guideline (CG190, December 2014). The trust was aware of the Royal College of Obstetricians and Gynaecologists' guidance, 'Safer childbirth: minimum standards for the organisation and delivery of care in labour' (RCOG 2007) as this was referenced in policies and procedures, and in the risk register when identified risks potentially affected compliance with RCOG.

- To inform and update staff regarding changes in policies, procedures, guidance or national standards, staff received information at team meetings, during handover, by email and through notices on the wards. A newsletter had been introduced that contained this information. The first edition had been released in January 2015. Not all staff we spoke with were aware of the newsletter; other staff expressed a view that it would be a useful tool to alert them to new and important information.
- NICE intrapartum care guidance (CG190) came into effect in December 2014, this was specifically regarding information provided to women regarding transfers of their care. The trust had developed an application for a tablet or smart phone to assist with shared decision-making for prospective parents and their midwife. A planned revision of the app was taking place to ensure it included information from the new NICE recommendations.
- The service encouraged normal birth whenever possible; 63.7% of women delivered normally within the service, compared with 60.4% nationally. The rate of caesarean sections was 0.5% lower than the England average. Women who had previously had a caesarean section were referred to a specialist midwife and discussed options regarding a vaginal birth after caesarean (VBAC) during their antenatal care.
- The trust's risk register identified that the trust had declared partial compliance with NICE's Antenatal and postnatal mental health guideline (CG192, December 2014). The trust had been proactive in addressing this and additional training for staff was ongoing. The trust was working with the Wessex Mental Health Network to develop services to ensure that multi-agency care and support were available to women developing mental health problems during and after their pregnancy.
- The women's services bereavement support team met every two months. Minutes of the meetings

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demonstrated new guidance and guidance currently in use had been discussed and action taken to ensure all staff were aware of new guidance and meeting requirements.

- A diabetes specialist midwife was in post. Antenatal diabetes clinics were provided; additional clinic hours had been created to ensure the increased numbers of women with gestational diabetes were provided with clinic appointments. NICE guidance regarding diabetes in pregnancy (NG3, February 2015) states women should be assessed for diabetes when they presented with one risk factor. The trust's guidance stated that women were to be assessed when two risks were identified, which meant the NICE guidance was not fully complied with.
- The endometriosis care team participated in data collection for local and national clinical trials that looked at different operative treatments, recovery and symptom relief. This ensured women attending the clinic were provided with up to date and evidenced-based care and treatment.
- A specialist colposcopy nurse managed outpatient and ambulatory clinics on the gynaecology day unit and had completed appropriate training and was accredited by the British Society for Colposcopy and Cervical Pathology. The nurse's re-accreditation took place every three years.

Pain relief

- Gynaecology patients on the ward (A6) were positive about how their pain had been managed. We reviewed medication records for five patients and saw regular pain relief had been offered, administered and recorded.
- Patient feedback from women on the labour and postnatal wards was positive regarding their experiences of pain control.
- Training was provided as part of the mandatory competencies midwives were required to achieve and keep updated. Basic analgesia training was completed every three years.
- An anaesthetist was on duty to provide emergency theatre support at all times. Their role was to provide pain management for women on the labour ward, including epidural management.
- We observed midwives and nursing staff administering medication on both a maternity and gynaecology ward. Staff asked women if they required pain relief during the medication round.

- We observed community midwives discussed pain-relief options during antenatal visits with women who were planning to deliver in a midwife-led community unit.
- Policies and procedures provided guidance for staff on the use of analgesia in child birth, such as for Entonox and pethidine.

Nutrition and hydration

- The trust had a baby-feeding lead who provided information and guidance to staff and women on the unit. Maternity support workers had undertaken training to enable them to competently assist women with feeding their babies. We received positive verbal feedback about the support one woman had received from a midwife support worker: "they really helped, I feel much better about it all now".
- A clean and comfortable breastfeeding room was available to afford privacy for mothers if required.
- Antenatal breastfeeding clinics were available to women in the acute and community units to provide guidance and information.
- The gynaecology ward completed risk assessments of patients' nutritional and hydration needs using the Malnutrition Universal Screening Tool. The ward used a red tray system to alert staff that a nutritional risk had been identified and that the patient required some form of assistance. Staff considered this system to work well and all grades of staff on the ward were aware of it.
- Patients all had drinks accessible to them. Fluid input and output charts were in place where a risk had been identified with patient's hydration. Although these records were not consistently completed, staff assured us this was as a result of recording errors and not lack of provision of drinks to patients. Clear pictorial information for staff was located on the ward and clearly showed the amount of fluid held in each type of drinking vessel, for example a glass or cup, to help staff accurately complete the fluid charts.
- Patients made positive comments regarding the food provided, saying the food was "tasty", "hot" and "big portions, more than enough for me". One patient showed us their menu and said there was a very good choice and they always got what they had requested.

Patient outcomes

- The trust gathered information relating to outcomes for women's service and this was made available in performance dashboards for both the maternity and

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gynaecology services. No concerns were identified in the information provided regarding maternal readmissions, emergency caesarean sections, elective caesarean sections, neonatal readmission rates or puerperal sepsis and other infections.

- The total number of deliveries was 5,966 in 2013/14, which brought the trust into the top 25% in England. The births were comparable with the England average when looking at the numbers of single and multiple births, for gestation period of under 24 weeks and to full term. There was a slightly higher than national average number of mothers aged below 20 and in the age groups 20–34. Lower numbers of mothers aged 35–39 and those aged over 40 gave birth within the trust compared with the England average.
- The maternity dashboard clinical scorecard for the year April 2014 to January 2015 showed that 76.5% of all births had taken place at the acute unit, 17.7% had been at the co-located unit at the hospital, 4.8% in community midwife-led units and 2.5% had been at the women's home.
- Data gathered identified that the hospital provided effective maternity services: 65.9% of babies were born by spontaneous vaginal delivery which exceeded the target of 62%; 1.5% of women experienced a third-degree tear when giving birth, which was lower than the England rate of 3%; 22.6% of women delivered their babies by caesarean section compared with the England average of 24%. This information was displayed on noticeboards on the wards for patients to see.
- The trust had introduced a postnatal pathway, with an additional visit by a midwife support worker three days after discharge. The midwife support worker weighed the baby and was able to provide feeding advice and guidance. An audit of neonatal readmissions showed these had reduced since introducing this pathway.
- The newborn blood spot screening is a blood sample used to assess newborn babies for five diseases. The risk register identified that there had been concerns regarding the number of repeat tests required because of an unsatisfactory specimen provided. This meant a possible delay in diagnosis and treatment. Action had been taken with support and training for staff taking place and new equipment purchased. Ongoing monitoring had shown a decrease in the number of required repeat tests.
- Newly qualified midwives were supported with a preceptorship programme for one year. Initial shadowing of an experienced midwife lasted for one month when first qualified. Support was provided to newly qualified midwives to gain competencies from a named mentor and the practice educators.
- The maternity services had developed a competency framework for maternity support workers, for example some were trained to undertake venepuncture and provide breastfeeding support.
- All midwifery staff were required to demonstrate competence in clinical tasks and skills. A record of competencies was maintained by the practice educators for each member of staff.
- Information from the trust website informed us that there were 24 supervisors of midwives. A supervisor of midwives is a midwife who has been qualified as a midwife for a minimum of three years, and has completed additional training in midwifery supervision in line with the Nursing and Midwifery Council rule 8, 2012. Training was carried out at Bournemouth University. The supervisor of midwives provided annual supervision to midwives, which included practice experiences and training discussed on a confidential basis. The maternity clinical service centre risk register identified an issue with a reduction in discretionary payment to supervisors, which had resulted in hours for individual supervisors of midwives increasing because there had been resignations in the cohort. The trust supervisor to midwife ratio was 1:15 in January 2015, which equalled the recommend national rate. However, the clinical scorecard for maternity services showed this had been higher than this for the previous six months and for a period of two months had been considerably higher at 1:24. We were told the Director of Midwifery had increased the hours of Supervisor of Midwife activity to 12 hours per month to address this, which resulted in improving the ratio to 1:15.
- Midwives rotated through the unit and community settings to maintain skills and competencies to care for women at all stages of their pregnancy and place of birth. This meant staff could be located within the service to meet the current demands and be competent to do so.
- Ongoing practical workshops and study sessions took place on the maternity unit, for example on water births. These were in addition to mandatory attendance at the obstetrics emergency drills sessions. These ensured staff

Competent staff

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kept up to date with new practice recommendations and were competent to deliver specific care and treatment to women. Team leaders had responsibility to ensure competencies were up to date and an accurate record was maintained for the midwife. The midwives met with their team leaders for supervision twice a year and during this meeting competencies were reviewed.

- Training for midwives on clinical examinations of the newborn was ongoing at the time of our inspection. We were informed that the launch of a new clinic was planned in April.
- Annual appraisals took place for all staff working in the gynaecology speciality. New paperwork had been introduced in March 2014 to improve the recording of the appraisals. As a result the completion of all annual appraisals had increased to 90%.
- The early pregnancy assessment unit provided a scanning service that was delivered by medical staff and two specialist nurses. A training course for scanning was available and ongoing for nurses to attend. Medical trainees told us they had requested to work at the early pregnancy assessment unit because of the opportunity of scanning training.
- The bereavement support team had set up training for nursing staff who provided care and treatment for women who underwent termination of pregnancy. Staff were provided with the opportunity to shadow senior staff when initially providing this care and treatment. This system ensured cascaded learning took place and emotional support was available to staff.
- Monthly training sessions for staff to attend were arranged on the gynaecology ward. For example, topics included intermittent self-catheterisation and oncology. Staff commented that these were useful and effective.

Multidisciplinary working

- Nursing, midwifery and medical staff we spoke with were all positive about the multidisciplinary working between departments and specialities within the trust.
- Doctors and midwives worked closely together and liaised with staff on the neonatal unit. Communication and effective team working ensured that transfers of babies to the neonatal unit from the maternity wards took place smoothly.
- During our inspection we observed prompt attention was provided to a woman and her baby from the maxillofacial consultant and specialist nurse following a referral made by the obstetrics consultant.

- An online referral system had been implemented to enable GPs to refer women to the midwifery service. Discharge summaries were in place to inform the GP and community midwives of relevant information regarding the women's birth experience. The maternity services had access to two obstetric theatres and teams from the wards and theatre worked closely together to ensure appropriate arrangements were made for women requiring surgery.
- Gynaecology staff received support and communicated effectively with the trust's surgical speciality to ensure the care of women requiring surgery was effective.
- A multidisciplinary team was in place for gynaecology cancer care in Portsmouth. This team consisted of doctors, nurses, radiologists, histopathologists and therapy staff who met weekly to discuss individual patients' treatment plans. Liaison took place between the team, the patient and their representatives before information was communicated to their GPs. A leaflet was available for patients outlining the services in place.
- The discharge process from the gynaecology ward was supported by specialist nurses, for example the oncology specialist nurse and the endometriosis specialist nurse.
- Girls under the age of 16 who presented with gynaecology problems that were non-pregnancy-related were admitted to the paediatric ward. Staff from the gynaecology ward provided advice and guidance if required. Teenage specialist midwives were employed by the trust and were consulted when necessary.

Seven-day services

- The trust provided 69.5 hours of consultant cover per week, with an on-call rota for out of hours and weekends. Consultants visited the wards at weekends as part of their on-call and out-of-hours work rather than contracted hours. This had been identified as a risk on the trust risk register, with an action to provide a business plan to the board to increase the consultant cover. Staff told us consultants were available and on site during the day and attended when called out of hours.
- Consultants were available out of hours, including during the night and at weekends. An on-call rota was in

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place and both nursing and medical staff reported they were able to contact the consultants at any time regarding the care and treatment of women who were patients on the wards.

- A specialist maternity physiotherapist was available four days a week. Outside of their working hours, access to physiotherapy was through the hospital's on-call physiotherapy rota. Staff told us they had experienced delays in accessing physiotherapy out of hours because of the demand on the service.
- Sonographers were available during the working week. Delays had been experienced in the past for women requiring a routine scan, following bank holidays or at peak times; therefore, the trust responded to this by the provision of additional capacity when there were anticipated increases in activity. The maternity day assessment unit was open seven days a week and midwife-led advice and guidance was always available.
- The emergency gynaecology unit was open seven days a week, with a senior registrar always on-call and consultant back up, to respond to admissions. Nursing staff were available in the unit during the day and cover was provided from the gynaecology ward at night.
- The early pregnancy assessment unit was open five days a week. At weekends and out of hours, patients who required treatment and care were admitted to the gynaecology ward or maternity unit.

Access to information

- There had been issues about the loss of information and notes when transferring the care of women and babies to health visitors. A secure group email inbox, for a single point of access, had been set up to address this issue and improvements had been noted. The safeguarding teams used this point of access for all referrals and transferring of information, and staff reported this had improved communication between the teams.
- Discharge information was provided to community midwives, who took over the care of the mother and baby following their discharge from the delivery or postnatal ward.
- Staff had access to electronic records that provided the results of tests, for example blood tests and scans, carried out for individual patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women were asked for their consent before any care and treatment were delivered. Verbal consent took place for day-to-day care and treatment. We observed staff explained any planned care and treatment and ensured the woman permitted this to take place, for example before taking blood or performing internal examinations.
- Written consent for surgical evacuation of retained products of conception was obtained.
- Information was provided about foetal tissue and consent was obtained before its disposal.
- We saw capacity assessments had been completed and best interest decisions documented following discussions with patients' representatives when necessary. This demonstrated compliance with the Mental Capacity Act (MCA) 2005. Staff we spoke with demonstrated a good understanding of the MCA and told us this was included within the mandatory safeguarding training.

Are maternity and gynaecology services caring?

Outstanding



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

We rated caring as outstanding.

Patients received an outstanding caring service as staff involved and treated patients with compassion, kindness, dignity and respect. Staff showed empathy and understanding to patients at all stages of their care and treatment. Patient's individual preferences and needs were reflected in how their care was delivered and they were encouraged to make choices and decisions regarding their care. Staff placed women at the centre of their care and treatment and fully respected their emotional and social care needs, which were embedded within the care and treatment provided. Staff demonstrated full awareness of cultural issues women experienced and had received consistently positive feedback from women attending this clinic.

The trust sought feedback in a variety of ways from patients and any issues raised were addressed by the trust. Patient's

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comments were overwhelmingly and consistently positive regarding the care and treatment they had received. There was outstanding emotional support for women following the birth of their child, and for women who may not of had the outcome or experience they expected, or had experienced the loss of a child at any stage during their pregnancy. Staff telephoned women following their discharge to discuss their experience and listened to the women's point of view. There were also support groups for women with gynaecological problems available which were attended and supported by nurse specialists.

Compassionate care

- The hospital participated in the NHS Friends and Family Test and encouraged patients to complete surveys regarding their experience of using the services. The response rates were better or in line with the England average.
- Feedback from the Friends and Family Test from January 2015 was displayed on noticeboards and showed positive outcomes. Results from the last four months showed that between 96% and 99.7% of patients were likely or very likely to recommend the service.
- The CQC survey of Women's Experiences of Maternity Services 2013 showed women's experiences were about the same as other trusts in England. The exception to this was regarding the length of stay women experienced following the delivery of their baby, where this was worse than other trusts. Additional midwife support workers had been appointed to provide additional care and support to women postnatally.
- The midwives who ran the new perineal outpatients clinic sought feedback by providing written quality surveys. We reviewed returned surveys and found all comments were positive. Such comments included "they were kind and understanding", "took the time to talk through my concerns", "so brilliant and willing to talk and listen" and "caring and considerate staff make you feel at ease straight away".
- The trust had an initiative in place called 'back to basics', which required staff to introduce themselves by name to patients with the belief this is the first step of compassionate care. We observed staff introducing themselves to women and their families and we saw that patients referred to staff by their first names.

- We observed staff providing care and attention to women in the maternity wards, community centres, and gynaecology wards and clinics. We saw staff promoted people's dignity, showed them respect, were polite and kind, and provided care in an unrushed calm manner.
- Patients we spoke with were positive about the service they had received and said their privacy and dignity were respected and they were treated kindly. We saw positive comments that had been received from patients in writing were passed onto the midwives and staff who had been involved in their care. One such email stated "it was the best experience I ever had".

Understanding and involvement of patients and those close to them

- The CQC survey of Women's Experiences of Maternity Services 2013 received positive responses from patients about information given in a way they could understand during their labour and birth.
- A midwife who was studying for a degree had raised awareness of the involvement of women during the handover period. Feedback from women had indicated they had not always felt involved in or understood their care. A system had been devised for handovers to take place at the women's bed so they could be included.
- Patients in the antenatal consultant-led clinic were positive about the kindness and information sharing from consultants and midwives. Comments included "they explain things in a way that is understandable", "the reasons for my treatment were given" and "he [consultant] put my mind at rest". One patient we spoke with had chosen to return to Portsmouth NHS Trust for the birth of their second baby despite having moved out of the area. They said this was because of the excellent care and support with their complex needs that had been provided during their first birth. They were also complimentary about the detailed information provided by midwives and how this had ensured they understood the care they required without being made to worry about their condition.
- Information sheets were available in the early pregnancy assessment unit, which staff went through with the patient. If patients were not ready or able to make a decision regarding their pregnancy at a first visit, the information sheets were available to take home. Staff stressed they would talk through the information again on subsequent appointments.

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Emotional support

- Follow-up telephone calls after their discharge home were made to mothers who had experienced difficult or complex deliveries. This enabled staff to offer reassurance and explanation, or to signpost the mother to where appropriate help or support could be obtained. Since the introduction of this system, records had been maintained and audited that showed the number of complaints had reduced. We looked at the records for telephone calls and saw one woman had wanted a normal birth but had to have a caesarean section because of unforeseen complications. The woman stated all staff “had been amazing” and she had received 1:1 care and support throughout. She added the breastfeeding support given to her had “literally changed my life”.
- Telephone calls were made to women after some gynaecology procedures to enable the patient to discuss and ask any questions to ensure their understanding of their situation.
- The early pregnancy assessment unit specialist nurse attended the bereavement team meetings and was the lead nurse for caring for women who had lost babies early in their pregnancy. Support was offered to women on both the early pregnancy assessment unit and maternity unit regarding chaplaincy and blessings for babies. Information and access to the Stillbirth and Neonatal Deaths Charity was available. Staff recognised and took patients’ cultural, religious and social needs into account.
- Following a loss of pregnancy on the gynaecology ward or a stillborn baby on the maternity unit, support was provided to women by the provision of 1:1 care. Memory boxes were available with contents that could be kept, used or removed to serve as a memory of the baby. Photographs were taken of the baby for the parents to keep. Staff supported women when providing these boxes and reviewing the contents because this was an emotive time.
- A support group for women diagnosed with ovarian cancer had been set up on the gynaecology ward and was attended by nursing staff. An ovarian cancer awareness campaign had been organised to take place in the hospital.
- A support group for people living with endometriosis was available. The endometriosis specialist nurse met

with patients on the wards before their discharge and telephoned them in the week after discharge. This was to ensure they were provided with information and were able to ask any questions they had.

Are maternity and gynaecology services responsive?

Good



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

We rated responsive as good.

Patients received a responsive service because the service provided was organised to meet the needs of women in their local areas and provided women with a choice of where they received their maternity care.

Community-based services were planned and delivered to women in their local area, for example antenatal and postnatal clinics and the midwife-led birthing units. Women giving birth had a short length of stay in hospitals because community midwives were available to manage postnatal care. The trust had an integrated care model and staffing levels were flexed to provide one to one care for women during labour. However, staffing levels on the labour ward had, on occasions, affected the choices women were able to make on where they delivered their baby. Because of pressures on medical beds, some medical patients were transferred to the gynaecology ward, which had increased the numbers of cancelled gynaecology operations. Additional gynaecology clinics and appropriately trained staff had been put into place to meet the increased demand of newly referred patients. There was a one-stop clinic for gynaecological assessment.

The service had developed extensive and innovative approaches to meet the needs of women, for example a mobile application to provide women choices at birth, sexual health services and a bereavement suite. There was a good understanding of the care needs for people with a learning disability or living with dementia.

Women were informed on how to make a complaint and complaints were monitored effectively by the women’s and children governance and quality committee.

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Service planning and delivery to meet the needs of local people

- The midwifery services were provided in both the obstetric consultant-led and a midwifery-led co-located unit at Queen Alexandra Hospital. Services were provided at midwifery-led centres in the community in Gosport, Portsmouth and Petersfield. Home deliveries were also an option for women. This gave women the opportunity to deliver their babies in a location of their choice whenever possible.
- Consultant- and midwife-led antenatal and postnatal clinics were held in various locations throughout the trust catchment area. Antenatal appointments were booked according to geographical location of where the patients lived, unless they were required to attend a specialist clinic held at the hospital.
- Antenatal clinics, breastfeeding support classes and teenage pregnancy education classes were held in community midwife-led clinics, enabling patients to attend a clinic near to their home.
- Women were able to go home after two hours if they and their baby were well. Community midwives then provided postnatal care to women at home. Midwifery support workers provided additional care and support at home for a longer period of time until the mother was happy to be discharged into the care of the health visitor.
- There were two dedicated obstetrics theatres. One theatre was used for elective caesarean sections and the other for emergency procedures such as caesarean sections or stitching of tears. This meant that women did not experience delays in receiving treatment.
- Changes had been made in the times of visiting on the postnatal ward, based on the needs and wishes of the patients. This was in order to avoid school leaving times and enable longer visiting hours.
- An audit had been carried out on the numbers of patients being referred to the colposcopy service. As a result of an increase in new patients, an additional colposcopist was trained last year to meet the local demand.
- The gynaecology day assessment unit provided a 'one-stop' clinic and enabled women to attend the unit for various treatments, including pre-assessment

checks, hysteroscopy, endometrial ablation, hysteroscopic sterilisations, polyp removal, post-menopausal bleeding investigation, colposcopy and smear tests.

- In response to identified need, a perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation

Access and flow

- The bed occupancy at the hospital was identified as being 15 - 20% higher than the England average. The integrated model which the trust maternity service runs (Nurture programme) allowed flexible use of staff to maintain 1:1 care in labour. Within the maternity service, the staff and patients were moved to ensure that women delivered their baby with 1:1 midwife support. This had kept women's denied choice of place of birth to a minimum. However, the access and flow of women through the maternity unit had affected where staff were required to work and on rare occasions affected the choices women could make on where they delivered their baby. In the last 2 audits (August - December 2014) of denied place of birth only 2.5 % of the women booked for a Midwifery Led Centre birth were unable to have a birth in their place of choice only one woman was unable to have a home birth. For example, one community midwife informed us of one woman who wished to deliver their baby at home but because of staffing shortages they had been asked to attend the community birthing unit. They had delivered their baby at the unit and not at home. We were also informed of another occasion when the community midwifery unit had not been staffed and one woman had delivered their baby at the hospital.
- Four antenatal beds had been changed into an induction room that was staffed 24 hours a day to assist with patient flow. This had been put in place after a number of complaints about delays experienced by women waiting to be induced. The hospital had carried out an audit of the experiences of women who had received treatment in this area and found there had been less delays experienced and the number of complaints had reduced. During our inspection

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induction treatment had halted for a short period of time because of pressures on the labour ward. Women were no longer given a date in advance to come into the unit to be induced but were telephoned when a bed was available. This reduced the distress experienced by women if their admission had to be cancelled.

- For gynaecology patients (October 2014), the trust was slightly below the target of 90% of patients waiting less than 18 weeks from referral to the start of treatment; this was agreed with Commissioners as part of the overall RTT plan to reduce patients on the waiting list. The trust achieved this for 89.1% of patients. The trust met the target for 92% of patient to be on the waiting list for less than 18 weeks from referral to treatment (the trust achieved 95.9%).
- The number of patients who were admitted to the gynaecology ward from other specialities had affected gynaecological surgery. The most recent gynaecology services management meeting identified 26 elective operations had been cancelled during December 2014 and January 2015 because of pressures on beds elsewhere in the hospital. An action plan had been put in place to address this and two surgical lists were to begin each Saturday from the end of January 2015 to ensure the backlog of elective operations was met by the end of March 2015.
- We saw one comment on NHS choices – a website where people can comment on the care and treatment received – that stated the person had experienced an excellent streamlined service for their surgery. They added they were admitted and discharged as per their pre-operative plan.
- Patients were discharged from the gynaecology ward with support and involvement from appropriate specialist nurses. This enabled patients to be discharged sooner with the right care and treatment.
- Referrals to the colposcopy clinic from GPs were placed on a waiting list depending on the level of risk. Patients with identified moderate risks were seen within two weeks of referral and those with low risks within six weeks. The biopsy results were provided to the GP to follow up with the patient.
- The emergency gynaecology service was available at all times. Additional staff had been provided to cover peak times between 8pm and midnight. Outside of these hours the nurses from the gynaecology ward and the on-call medical staff provided care and treatment.

- There were four additional beds located in an area adjoining the gynaecology ward that could be opened and used when necessary. The beds were staffed by the ward staff.
- Delays had been experienced in the past by women requiring a routine scan after bank holidays or at peak times. The service had been proactive in addressing such periods of time and additional clinics, for example during the evening or on a Saturday, had been organised. This had ensured women had received their scan appointments in timely way. During our inspection consideration was being given to the forthcoming Easter period and additional clinics were planned.

Meeting people's individual needs

- Women were provided with guidance and support about their choice of where to give birth. A decision-making tool in the form of an application for a tablet or smart phone was available for women and helped with shared decision-making for prospective parents and their midwife.
- Information was gathered about whether women had given birth in their chosen place. If the chosen place of birth had been declined, the reasons were discussed between individual staff and the supervisor of midwives. An audit conducted in September 2014 found that 1.3% of women had been denied their choice of birth place.
- Screening for women's mental health status took place by community midwives when booking-in new patients. A mental health specialist midwife was in post and provided support to women with mental health issues in pregnancy together with one of the obstetric consultants who had a specialist interest in perinatal mental health. Patients who were admitted with a pre-existing mental health condition often were supported by a community mental health team and staff told us they would liaise with them. A referral could be made to the hospital's mental health team for newly diagnosed patients.
- The bereavement suite on the maternity unit offered women and their partner's 1:1 care. They were able to stay together with their baby for as long as they needed.
- The day assessment pathway was part of a regional initiative to provide consistent information to women regarding their specific care needs, such as on ruptured

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membranes, small baby for dates, and itching in pregnancy. The pathway ensured the same advice was given to women and had reduced unscheduled antenatal appointments and admissions.

- A fast-track referral pathway to sexual health services was in place for any women identified as infected with HIV or syphilis, and to the hepatologist and specialist nurses for infection with hepatitis B. This ensured women received prompt and appropriate treatment.
- Partners were not permitted to stay with women unless they were being induced or were in established labour on the labour ward. Women had requested their partners be able to stay overnight with them in the maternity unit for emotional support. Because of the potential impact this could have on other patients in the unit, a survey had been carried out. A decision had not been reached about this at the time of our inspection. The exception to this was for women who were admitted to the unit from the Isle of Wight, Jersey or Guernsey who were provided with a side room so that their partners were able to stay with them without impacting on other patients on the ward. Noticeboards showed photographs of staff in departments and wards. Pictures of uniforms identifying the staff roles were on display. This enabled patients to identify staff and their jobs to make it easier for patients and visitors to identify appropriate people.
- The gynaecology ward had developed a discreet flagging system to alert staff to patients living with dementia. This was in the form of a flower-shaped magnet located above the patient's bed or outside of their room. The ward had a dementia link nurse who had attended additional training and provided support to other staff on the ward regarding the care of patients living with dementia. Staff we spoke with were unaware of access to dementia specialist nurses within the hospital.
- A learning disability specialist team was available to staff in the hospital. The gynaecology ward had accessed this support and commented it had been useful.
- Translation and interpretation services were available by telephone. Some information was available in different languages.
- The trust had a user-friendly website for the public that provided information on hospital departments, wards, conditions and treatments. The trust's website enabled prospective patients to take a virtual tour of the

midwifery services, including the co-located unit, labour ward, scanning department, theatre suite and the community midwife-led units. Women were also welcomed into the hospital to look around before their admission. For patients who were to be admitted to the gynaecology services, information was available online about the layout of the hospital, where to go and what to take into hospital.

- Patients could sign up for emails and text messages for information covering key pregnancy and baby topics.
- An application (app) for a tablet or smart phone was available for women and assisted informed choice for prospective parents on aspects of their forthcoming delivery.
- The antenatal waiting area had television screens to identify appointment waiting times and if the clinic was running late. Information was also provided to waiting patients about relevant issues. At the time of our inspection, information on influenza was displayed.
- Family planning advice and guidance was provided to women post-delivery and also on the gynaecology ward and early pregnancy assessment unit when necessary.
- Leaflets were available on wards and departments for patients to access regarding specific conditions and treatments.

Learning from complaints and concerns

- Information about how to make a complaint was seen within the hospital and available to patients and staff. Additional information was available on the trust's website and included guidance on how to contact the patient advice and liaison service.
- The women's and children's governance and quality committee monitored complaints to identify any themes or trends and took action as required. For example, a series of complaints had identified issues about consistency of advice given to women before admission on when they should come to the labour ward for admission. Changes had been made to the triage process as a result. A nominated person supported staff with managing the new system and addressing any further complaints.
- The chair of the midwifery liaison committee visited clinics and children's centres each week to speak with women and gather information on their experiences. The trust was responsive to any concerns raised by the chair on behalf of women she had met with.

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Are maternity and gynaecology 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 service was well-led because the leadership, management and governance of the organisation assured the delivery of high-quality person-centred care and promoted an open and fair culture. Quality of services was monitored in staff meetings and governance meetings in both the midwifery and the gynaecology services.

Staff were positive about the management of their services and the accessibility to their line and senior managers.

The service welcomed public engagement and this was actively sought through the NHS Friends and Family Test, telephone conversations as part of the postnatal pathway, national and inpatients surveys and from feedback from the chair of the midwife liaison committee who spent time with women to discuss their views and experiences.

Innovative practice was encouraged and in evidence within the service, including the development of an application to be used on smart phones and tablets enabling women to access information to make choices and decisions regarding their birth. Student midwives had support from experienced community midwives to run a postnatal clinic to increase their knowledge and competencies.

Vision and strategy for this service

- The staff were able to tell us about the values of Portsmouth Hospitals NHS Trust, which were embedded into the service. We saw posters displayed that informed patients, visitors and staff of the aims of the hospital: best hospital, best people, best care.
- The Nurture three-year project had been introduced to redesign the service provided to women using maternity services in Portsmouth and the surrounding areas. This had led to 1:1 care being delivered to women in labour

and additional antenatal and postnatal support to women from midwife support workers. Stage two of Nurture was being implemented, part of which was implementing and redefining evidenced-based pathways and engaging with women and enabling them to access electronic information.

- Information was displayed clearly at the entrance to the gynaecology ward identifying that the trust's aim was to deliver first-class holistic women and children's care. Staff we spoke with were aware of this aim and considered the gynaecology services provided this.
- New noticeboards, known as transparency boards, had been installed on the maternity wards. These contained information on the trust's visions and values, feedback to patients and staff, and information regarding the hospital and services provided. Staff we spoke with told us they were new and were not fully aware of the information contained on the board or who had installed them.

Governance, risk management and quality measurement

- The gynaecology and midwifery services had local service risk registers that linked to the trust-wide risk register. Senior staff we spoke with were aware of the risks that were identified to their service and the action that was being taken to reduce the risk.
- The gynaecology and midwifery services held clinical governance meetings with minutes and actions maintained. Minutes we saw identified safety and effectiveness within the service was reviewed during meeting and actions were identified to improve the service.
- The medical staff held governance meetings during which case discussions took place to review if practice could have been improved. The meetings were attended by consultants, junior and middle-grade doctors from both the obstetrics and neonatal teams.
- All NHS Friends and Family Test responses were reviewed and any trends identified and addressed. For example, there had been comments made regarding the food supplied. These had been discussed with the catering team. Feedback was given through the Friends and Family Test forum. The gynaecology ward was planning to purchase a television in response to comments made.

Leadership of service

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- The midwives we spoke with, without exception, stated all managers were approachable, from their line managers up to the director of midwifery. We heard managers had an open door policy and all staff, including students and newly qualified midwives, were encouraged to approach and discuss issues. Recently appointed staff commented on the warm welcome and friendly atmosphere on the maternity unit.
- We spoke with seven midwife support workers who said they received support and guidance from their line managers.
- Staff on the gynaecology wards said their line managers and senior managers, including the service lead, were approachable and they felt listened to. They were confident action would be taken to address issues raised with their managers.
- Systems were in place for maternity and gynaecology issues to be shared with the executive board of the trust. Senior staff from the maternity service told us they had access to the board and felt listened to.
- Key messages were delivered to staff from the trust board by email. Staff were aware of these and commented on how the emails had contained ten top tips that had been useful to keep them up to date with current events and changes.
- All staff we spoke with knew who the chief executive officer was and commented they were aware of their visits to the wards and departments. The recently appointed director of nursing had attended the wards recently to introduce themselves. Staff were not knowledgeable about other board members.
- The gynaecology services on wards A5 and A6 had received a gold accreditation presented to denote excellent performance by the heads of nursing across the trust.

Culture within the service

- Staff we spoke with told us they were proud to work for the trust and service, and were supported to provide high-quality care to women and babies.
- Staff from both the gynaecology and midwifery units told us the staff worked well as a team, both within their units and within the wider trust. The majority of staff considered they were supported by their managers.
- Medical and nursing staff were respectful of each other and worked well together. A conflict of opinion policy had been developed by the trust and identified the process to follow should medical and nursing/midwifery

staff not agree on a care and/or treatment plan. Midwives told us they believed the medical staff respected them as the advocates for women and their opinions were respected.

Public and staff engagement

- Women were consulted and their views heard by the chair of the midwife liaison committee, who visited women in community and children's centres to hear their experiences of the midwifery services they had received. The chair reported to us they had access to senior managers in the midwifery department who listened carefully and acted on information shared. Staff were positive about the chair's role and considered her to be proactive, providing a link between commissioners and the trust and a pivotal member of the team.
- Feedback was obtained from women within the hospital using the NHS Friends and Family Test and telephone calls were made to some women after their discharge. This included telephone calls to women who had had a complex or difficult delivery or who had attended the hospital for treatment for endometriosis or a medical termination of pregnancy.
- Consultation had taken place with the staff regarding changes in staff shift patterns. Three members of staff we spoke with had understood the changes were to be short term, but had become permanent without further consultation. Other staff were not of that opinion and had received information and support during the period of change. A number of staff expressed concern for community midwives as they now rotated quickly from nights to days in order to cover clinics, which left limited time for sleep.
- The trust provided an online system for women to give their feedback on the service they had received. NHS Choices is a website that enables patients to review hospital services provided and the trust accessed this site and took notice of feedback patients had left.

Innovation, improvement and sustainability







- The Nurture model of care had been introduced within the trust's maternity services three years ago. This was an intense women-focused modernisation project, providing a redesigned service for women and children from pre-birth to the age of two. One main outcome from Nurture was the provision of 1:1 care during labour, which was now in operation. Nurture stage two was

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being implemented at the time of our inspection. This stage planned to develop the information-sharing technology available for women, involved women in developing the midwifery services and increase services where women require them. An example was the early feeding project where additional midwife support workers were employed and trained to provide extra postnatal support to mothers. This included reweighing babies after three days. This had demonstrated a reduction in readmissions for babies.

- The trust had a project team involved with developing and producing a book to provide information regarding safe infant feeding after concerns arose around the shared experiences of women who initially breastfed their babies and quickly changed to bottle feeding. There are national concerns about the high levels of obesity in babies and children and it was felt guidance was needed to help women understand breast and/or bottle feeding.
- The Smile clinic is a student midwife-led postnatal clinic developed to increase the exposure and experience of student midwives in providing postnatal care at St Mary's midwife-led community centre in Portsmouth. A study of the programme was being used by a midwife as part of their PhD at Bournemouth University. Student midwives were positive about the experience and learning gained from the Smile clinic and informed us that they had requested a placement at Portsmouth Hospitals NHS Trust as part of their midwifery training because of the clinic. Plans were in progress to introduce additional Smile clinics to the Gosport and Petersfield maternity-led birthing centres.
- The Phoenix project is an innovative programme to increase the delivery of localised care to women who live within a 10–15 mile radius of Petersfield and make the services more accessible and well known. A team was being developed to provide antenatal and postnatal care as well as increase the numbers of births at the Grange midwifery-led birthing unit and at home.
- My birthplace – the application (app) provided to share information on choices of birth place with women – is being revised to strengthen information about transfers of birth place when necessary. Information on the planned app was shared with women who used the services and their views taken into account during its development. The trust was proud that the app was developed with and for women who use their services. The trust was currently working with other hospital trusts who were purchasing the app and assisting them with the adaptation of the app to meet their specific needs. Additional money through grants had been applied for to further develop the app. The app won an award from NHS England in the excellence in people category. The service has also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- A newly implemented perineal clinic was running in the gynaecology outpatients department, providing care and treatment to patients who experienced third- and fourth-degree tears during childbirth. Women who had experienced female genital mutilation were also provided with care and treatment at this clinic and their options discussed.

Services for children and young people

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

Information about the service

Paediatric services moved to the main hospital site in 2009 when the new hospital building was opened. General paediatric medicine, surgery and diagnostic services are provided within a purpose-built paediatric unit. This includes a children's assessment unit (CAU), a 24-hour service accepting paediatric medical referrals 0–16 years; A7 Starfish ward, with 24 inpatient beds for children and young people with medical conditions 0–16 years; A8 Shipwreck ward, with nine inpatient beds and nine day surgical beds caring for children and young people up to 16 years. There is also a paediatric diagnostic imaging department. Children's outpatient clinics are provided Monday to Friday, within two clinic areas in the unit.

There is a neonatal unit on the first floor, which is a level three tertiary referral unit for medical neonates, and a community neonatal nursing service. The trust also provides a regional neonatal transport team, for transporting babies requiring specialist treatment and services.

Most young people over the age of 16 years are admitted to adult wards. There is no paediatric intensive care unit at the hospital; children and young people are cared for in the hospital critical services or transferred to the specialist unit at Southampton Hospital.

Before and during the inspection, we reviewed performance information from, and about, the service.

During the inspection we visited all areas of the paediatric unit, the neonatal unit and some adult wards. We also received feedback on care of children and young people from inspection teams visiting critical care and surgical services.

We spoke with 50 members of staff. These included senior ward sisters, nurses and nursery nurses, junior and senior doctors, specialist nurses, research nurses, play specialists, therapy staff, ward clerks, housekeeping and support staff. We also spoke with clinical and operational managers.

We observed care and treatment, looked at 20 care records and spoke with 30 parents, children and young people.

Services for children and young people

Summary of findings

Children, young people and their families were very positive about the care and support they received. They told us they were kept informed and involved in making decisions and were partners in their care. There was a strong family- and child-focused culture in the service.

The paediatric unit was purpose built and provided a bright and 'child-friendly' environment. Original plans included a ward for teenagers and adolescents, but this ward was now used by another service. We found facilities for teenagers on the unit were limited and they were sometimes cared for in bays with children and babies of all ages. There was no designated high dependency area; due to a shortage of cubicles the original space allocated for the high dependency unit was converted to accommodate small babies, and so these patients were spread across the medical ward.

There was no single point of access for emergency care; the children's emergency department and children's assessment unit (CAU) had different roles in the pathway, which was not always clear or efficient. But children and young people known to the service, with long-term conditions, had direct access to the CAU. The service had identified these issues as part of their strategic ambitions but detailed plans were still in development.

There were effective procedures to support safe care for children and young people and to keep them safe from avoidable harm. Staff were aware of how to report incidents and this information was monitored, reviewed and learning was shared with the staff. There was sufficient medical staffing, team working, protocols, robust records and communication, to support safe care and manage risk. Nursing staffing levels and skill mix were planned using national guidance with contingencies for staff to work flexibly across the service as required. But a formal acuity tool was not used for assessing staffing levels to meet patient needs.

Care and treatment was provided in line with best practice guidance and outcomes were positive. The outcomes for babies on the neonatal unit were good when benchmarked against other services. Staff were

well trained and supported in their role and provided with development opportunities. There was good multidisciplinary team working and a seven-day service was established.

The service had strong and visible leadership. There was a culture of continual learning and improvement, which was supported by strong leadership and multidisciplinary team working. Risks and quality were monitored at all levels, with action taken and changes made when needed.

There was good communication and engagement with staff, and innovation was encouraged. Children and young people and their parents were encouraged to provide feedback and ideas for improving 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 safe care for children and young people. There was openness and transparency about safety, and continual learning was encouraged. Staff were supported to report incidents, including near misses, and learning was discussed and cascaded. Improvements to practice were made in response to internal and external safety events.

The environment was purpose built, but did not have a suitable designated area for high dependency patients who were cared for on the medical ward. There were secure access systems in place to promote safety, but arrangements out of hours were not as robust as during the working week. Age-appropriate specialist and emergency equipment was available and maintained. Medicines were appropriately managed.

Staff were clear about their responsibilities if there were concerns about a child's safety and the process to follow for a missing child. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding and other mandatory training. Staff were aware of their responsibilities if a major incident was declared.

A paediatric early warning system was used for early detection of any deterioration in a child's condition. There was sufficient medical staffing, team working, protocols, robust records and communication to support safe care and manage risk. Nursing staffing levels and skill mix were planned using national guidance, with contingencies of staff working flexibly across the service as required. But there were an increasing number of children and young people requiring 1:1 care on the wards and no formal acuity tool to assess changes to staffing establishment. Staffing levels were stretched when additional bank or agency staff were not available.

Incidents

- There were two serious incidents reported in 2014, all related to babies. All incidents were investigated using root cause analysis and learning was identified.
- Staff were confident in using the electronic reporting system to report all incidents and received initial feedback by email. There was a list of incidents that should automatically trigger an incident form as 'events' the unit needed to 'keep track of'.
- All staff were actively encouraged to report incidents and were praised for doing so. For example, a ward clerk told us they received positive feedback on reporting an incident of a security breach.
- We saw reporting and learning from incidents, including near misses, through a multidisciplinary team approach. All incidents were investigated with lessons learnt fed back to staff at individual and multidisciplinary team level. Changes in practice were also displayed on a 'Top Tips' white board.
- We saw examples of presentations to the multidisciplinary team at the monthly Friday information and learning meeting. These included learning from incidents and changes to practice. For example, an incident relating to intravenous fluids and a neonate resulted in changes to the high dependency observation chart to record regular checks of cannula site and pressure.
- The service used a multidisciplinary medication incident management tool. There were learning and development resources to support doctors, nurses and pharmacy staff following medication errors. A reflective practice sheet was used to support individual learning by nursing and medical staff following any medication errors, to prevent repeat of errors. Additional training for doctors and nurses had been arranged in response to medication incidents, including near misses. At inspection we saw that medications errors were included in safety display in the units, no medication errors had been reported during the month
- On the neonatal unit (NNU) an incident of breast milk being given to the wrong baby resulted in no harm but had led to changes in labelling and review of the use of the milk warmer. Debriefing was held after incidents on the unit.
- Safety alerts were sent to ward/unit sisters and cascaded to staff by email and displayed on the 'Top Tips' board and at handover.

Services for children and young people

- There were monthly mortality and morbidity meetings; nurses as well as doctors were encouraged to attend for discussion and learning.
- The trust hosted six-monthly road shows attended by the paediatric critical care staff along with colleagues from a neighbouring trust paediatric intensive care team. Case reviews and reviewed learning points and changes to practice were discussed.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS
- Information posters on duty of candour were displayed in the NNU and in staff areas of the paediatric unit. Staff had also been provided with guidance on duty of candour for moderate/severe incidents, including a flow chart, checklists for patient notes and letters to be sent. At the time of inspection this process had not yet been needed within the service.
- All staff we spoke with understood the principles of openness and transparency; nurses told us that the ward sister talked to parents if anything went wrong.

Cleanliness, infection control and hygiene

- There had been a cluster of MRSA colonisations in the NNU in July 2013, which had been investigated and addressed, with no reoccurrence. There had been no cases of MRSA bacteraemia in the service during 2014. There was an information leaflet for parents explaining MRSA.
- All areas were visibly clean and kept tidy. The external contracted cleaning staff were part of the ward team. We observed cleaning of areas after patient discharge, using ward cleaning schedules.
- Environmental cleaning audits were regularly undertaken and consistently scored over 95%.
- We observed staff adhered to the infection control policies, including 'bare below the elbows', hand hygiene and appropriate use of personal protective

equipment, such as disposable aprons and gloves. Extra care was taken for children and young people with suppressed immune systems, including cohorting and appropriate use of isolation facilities. There was a sufficient number of side rooms across the unit for isolation. There were signs outside isolation rooms reminding staff of transmission risks.

- Hand hygiene observation audits were undertaken monthly. Overall scores for NNU were 99% in November 2014, 94% in December 2014 and 97% in January 2015. The paediatric unit scored 100%.
- There were daily visits from the infection prevention control team, and advice was available if required.
- Signs reminded staff and visitors to use hand hygiene gel to sanitise hands at admission to the unit and wards. The door handle to the NNU was designed as a hand hygiene gel dispenser, to ensure everyone used hand disinfectant before entering the unit.
- On the NNU there were filtered taps and a daily supply of sterile water for each baby. Personal protective equipment was available and used at each cot side.
- There were designated areas on the NNU for used/dirty equipment, which was then cleaned and marked with stickers stating clean and ready for use. The paediatric wards had a storage area for clean equipment and had started using stickers on equipment, with date of cleaning and 'I am clean'.
- Families commented positively on the cleanliness of the units and staff hand hygiene. For example, 100% of respondents to NNU Parent Feedback survey, January 2015, stated that the unit was very, extremely clean. One commented "the doctors had really good hygiene practice, they would also tell visitors to wash hands if they had not done so".

Environment and equipment

- The paediatric unit was purpose built and provided a 'child-friendly' environment. There were two playrooms and a school room and access to an external play area. There were a variety of toys and play equipment.
- The paediatric unit was a locked unit, with receptionist entry 9am to 5pm Monday to Friday. Out of hours, all visitors reported to the main reception desk and the door to the unit was released to allow access. Reception staff raised concern that there was a higher risk of 'tailgating' through the doors at these times because

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main reception staff were further away from the unit. We observed visitors holding the door open for others; there were no signs asking people not to let others into the unit.

- The east entrance to the children's assessment unit (CAU) was locked and accessible by swipe card only from the outside; however, parents and visitors in the waiting area used the internal release button to let others into the unit. There was a receptionist/ward clerk in the room, but there was a potential risk of unauthorised access.
- There was no designated high dependency unit; due to a shortage of cubicles the original space allocated for these patients was converted to accommodate babies in cots.
- There were two paediatric outpatient clinic areas, with 15 consulting rooms and facilities for a range of specialities including fracture clinics and eye clinics. There was a designated waiting area for teenagers in outpatients.
- There was a dedicated paediatric theatre accessed by a patient-only lift and corridors decorated with animal pictures. The waiting area was colourful with lots of distractions and TV games. Screens were used to shield children from any theatre activity. There was a paediatric-only recovery area in working hours. Out of hours a dedicated area was identified so children were not mixing with adults.
- There was a paediatric radiology suite (x-ray and ultrasound) within the paediatric unit. All areas including changing rooms and waiting area were appropriately decorated and 'child-friendly', and promoted privacy and dignity. It was a reassuring, quiet and calm area.
- The NNU was a secure unit with entry by call bell system.
- On the NNU, parents had a specified area for eating and drinking away from the cot side. There were four parent rooms. The paediatric unit had a parents' rest room, two bedrooms and beds for parents at the patient's bedside.
- All areas were wheelchair accessible.
- The paediatric unit and the NNU were well equipped. An equipment officer oversaw the ordering of equipment and making sure equipment was charged, quality tested and ready for use.
- There was a schedule of maintenance for specialist equipment and hoists. Equipment in the resuscitation room had been recently serviced.

- Emergency trolleys were found to be appropriately sited and stocked. Emergency equipment was regularly checked and we found all in date.
- There was no paediatric intensive care unit (PICU) at the hospital, but the intensive care unit (ICU) had appropriate facilities for children, including paediatric resuscitation facilities. There was a designated room with support for child and parents that was seldom used for other purposes.
- The ICU had an appropriate range of equipment. Because they were seeing more children less than 10kg in weight, to provide necessary adequate ventilation and ensure safe practice they purchased a 'babylog' ventilator. This meant that all small children and babies could be appropriately and sufficiently ventilated.

Medicines

- Medicines were securely stored in locked cupboards, drug fridges and controlled drug cabinets in treatment rooms secured by keypad locks. There were records of daily checks to confirm medicines in fridges were kept at optimal temperatures.
- We observed medication injectors for the treatment of anaphylaxis on a low trolley in the CAU for easy access in an emergency. We raised concerns with senior staff so that these could be moved out of the reach of children.
- Allergies and weights were recorded on prescription charts, and administration records were complete on those we reviewed. There were monthly audits of prescription charts against trust medicines management standards, with findings shared with staff and actions taken to improve practice, such as additional training.
- The pharmacy lead provided prescribing training on paediatric induction. Additional funding had been secured for prescribing training for non-paediatric surgical trainees.
- Medicines to take home were dispensed on the ward and take-home medicine packs were checked by nurses.
- Parents assessed as competent, and following a protocol, accessed the individual medicines cabinet to administer medicines at the correct time to fit in with the child's daily routine. Parents were clear on the medications prescribed. Some parents were trained and assessed to administer intravenous antibiotics and there were guidelines for parents and young adults on home intravenous antibiotic therapy.

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- Trusts data showed 91% of nursing staff had completed medicines management training. NNU staff attended annual updates on medicine management, in particular morphine and insulin. There was annual training for multidisciplinary staff on learning from medication incidents.
- A 'Neonatal medicines management at your finger tips' App for mobile phones was available for staff to use to support safe medicines management.

Records

- Paediatric patient records were multidisciplinary and standardised. There were assessment and care record documents for specific care pathways, such as head injury, orthopaedic and trauma, children's traction, ENT and surgical emergency.
- The care records covered relevant assessments of care needs and risk assessments.
- Care plans were patient centred and personalised. For example, it was noted that a child had had a previous bad experience with a cannula.
- Patients were weighed and their height measured. Observation charts, paediatric early warning systems (PEWS) and fluid charts were completed and totalled. High dependency observation charts were completed for higher risk patients.
- Records showed daily review of patients by consultants and clear management plans.
- Paediatric and neonatal services performed well in a trust-wide audit of patient records. All those we reviewed were well completed with date, time and signatures.
- We saw the five steps to safer surgery checklists were completed for children and young people who had undergone surgery.
- Medical and nursing staff used handover records, and safety checklists were completed at the start of every shift to highlight and manage any safety concerns.
- The bleep holder's guidance folder was not up to date, was poorly indexed and had lots of handwritten amendments and additions.

Safeguarding

- A named nurse and named doctor for safeguarding children and young adults were available for assessment, advice and to ensure the trust fulfilled its

legal obligations. There was a clear policy and procedures for safeguarding children and young people, with guidance on what to do and who to contact if there were any concerns.

- Trust data received before our inspection showed the following compliance with training in safeguarding children in the children's health and neonatal unit (NNU):

level one – nurses 97% (99% NNU) and medical 93% (87% NNU)

level two – nurses 88% (88% NNU) and medical 89% (35% NNU)

level three – nurses 77% (89% NNU) and medical 77% (48% NNU).

At inspection in February we found 95% of NNU staff were trained to level three, and all consultants had attended level three training.

- Staff were also required to attend safeguarding adults training. Trust data received before our inspection showed the following compliance:

Child health – nurses 96% and medical staff 86%

NNU nurses 99% and medical staff 100%.

- Mandatory training for paediatric services had recently been extended to include risk for domestic violence protocols.
- Safeguarding was considered within all assessments; a safeguarding checklist was completed on admission to CAU or the wards, and staff checked if children were subject to a child safeguarding plan. Safeguarding questions were recorded in paediatric and NNU records. Staff used safeguarding children proformas to document details of safeguarding concerns. In-house training on the use of proformas was provided and the documentation was audited. A guidance document had been developed to support correct completion
- On the NNU, when there were concerns, daily parenting observation charts were used to monitor parent-baby interactions, feeding of baby, safety and hygiene.
- Parenting education sessions were undertaken before parents took babies home from the NNU.

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- Any safeguarding or security issues relating to families and babies were highlighted at handover. This has had greater focus since an incident of assault on a neonatal nurse last year.
- There was a child abduction critical response policy and an updated version of the child and infant abduction policy was in draft.
- Staff reported an increase in safeguarding issues but felt well supported by the children's safeguarding team who provided ward-based training and helped develop individual care plans. Community staffed child protection clinics were held on the unit and staff were kept informed of progress with any alerts raised.

Mandatory training

- The trust had an 85% target for compliance with mandatory training. Trust data received before our inspection showed compliance rates of 90–99% for nursing staff across the range of training, including blood awareness, complaints and claims, risk management, infection control, basic life support, health and safety, fire safety, and moving and handling. Compliance with training by medical staff was lower in some areas, such as 63% for fire safety and 64% for infection control.
- Mandatory training for paediatric services had been extended to include simulation training covering PEWS and escalating concerns. This was now mandatory for every member of staff, including nurses, nursery nurses and child support workers. The plan was to progress to multidisciplinary simulation sessions for 2015.
- NNU staff attended an annual neonatal mandatory training day and the practice educator on the unit checked electronic staff record competencies. Training included simulation exercises.

Assessing and responding to patient risk

- The service followed a SAFER bundle for paediatrics in Portsmouth, which detailed processes to underpin safe multidisciplinary care. It included appropriate assessment, regular review and communication of any concerns about children and young people in their journey through the service.

- Staff used PEWS to identify and escalate deterioration in a child's condition. PEWS observation charts for children of different ages clearly identified when observations were outside the normal range and actions to take for different scores.
- A red flag system was used to highlight patients of concern (including some who were not officially high dependency but needed closer assessment).
- The paediatric team took ownership and supported any child who became medically unwell on Shipwreck surgical ward. There was a protocol and clear guidance for assessment and review of any surgical patients by the surgical team.
- There was an allocated bleep holder on the paediatric unit at all times, whose role was to have an overview of the unit and respond to any issues requiring escalation. They held regular mini-briefings with ward sisters. The management pathway for any critically unwell child gave clear guidance of steps to take and numbers to call for support.
- Junior doctors and 19 nurses had completed paediatric intermediate life support training. Four nurses had completed advanced paediatric life support training. This enhanced skills in assessment and treating the deteriorating child.
- An urgent facts book with information on patients presenting with unusual/specific problems was available to clinical staff on the unit.
- The service did not have PICU services but worked closely with the hospital's ICU, which provided care and treatment for some critically ill children and young people. Both paediatric services and the ICU worked in close liaison with Southampton PICU. Clear protocols and transfer arrangements were in place for children needing treatment on the specialist unit.

Nursing staffing

- The service told us staffing establishments for the wards and the CAU were based on Royal College of Nursing guidance for paediatric wards, professional judgement and benchmarking by the Association of Chief Children Nurses Group. Different staffing for children under and over two years old had been taken into account, looking at activity and occupancy levels day and night. A lead for workforce within the trust provided peer review.
- Nurses were all paediatric trained; staff worked 12-hour shifts. The establishment was:

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- Starfish 24-bedded medical unit: five nurses and one nursery nurse day and night. We found this was minimal, and would not always allow for the nurse in charge of the shift to be supernumerary to ensure effective management, training and supervision of staff working on that shift.
- Shipwreck surgical ward (nine day case beds and nine inpatient beds): four nurses and one nursery nurse in the day, two nurses at night for the inpatients.
- CAU (15 care spaces): had a 1:5 nurse to patient ratio. There were four nurses in the day up to 8pm and three nurses at night when attendance dropped.
- The staffing budget was flexible over winter and summer, with a budget for an additional 5.8 staff in winter to allow for additional medical patients in the CAU/Shipwreck and to accommodate an increase in acuity. At the time of inspection there were four nurses on maternity leave and five whole-time equivalent band five vacancies, a 9% vacancy rate. Two nursery nurses had been appointed to backfill maternity leave and recruitment of nurses was ongoing.
- The rota accommodated some 1:2 care, but there was no designated budget for patients requiring 1:1 care. Along with vacancies, this created gaps in rotas that were covered by National Healthcare Service Professionals, often worked by staff from the unit and if necessary agency staff.
- Staffing levels and skill mix were assessed on a daily basis in relation to needs of patients on the ward at the time, based on the judgement of the nurse in charge in consultation with senior nurses. There was no formal tool to assess the acuity of high dependency patients and the required staffing levels.
- Senior ward sisters had a supernumerary role, but were often needed to support the clinical area because of staffing shortages. There were two senior sisters in post with plans progressing for the appointment of a third. They told us they would benefit from more administrative support.
- The bleep holder folder contained escalation plans, including clear instructions on how to cover staff shortages. Staff rotated across the paediatric wards every six months so they were familiar with the wards if they needed to move to cover staffing gaps. Nursing cover was also provided by the NNU.
- Safer staff levels were clearly displayed in each ward and we observed that the wards were one nurse less than planned on seven shifts during the inspection week. Staff were moved across the unit to assist where most needed. Staff were busy but worked very well as a team and were confident they were providing safe care.
- Occasionally the acuity of patients and staffing levels meant the nurse in charge was allocated patients. We saw this on one day of inspection when the nurse in charge of Starfish was allocated four patients. They were not concerned about having this extra workload but felt they could not provide oversight of junior staff or oversee patient flow.
- The contingency plan for paediatric bed and nursing shortages gave clear guidance for the duty paediatric consultant and bleep holder to follow if 'in their professional judgment they believed safety of children to be at risk because of workload/clinical condition of patients or staffing shortages'.
- We saw there had been incidents on 16, 18 and 25 September 2014 where agency staff had not arrived and had left low staffing levels. The ward sister told us that the service had needed to close to admissions on only a handful of occasions because of low staffing.
- The NNU was staffed at 1:2 or 1:1 nurse to babies, based on acuity. Staff worked flexibly and an escalation plan was used to cover any gaps in staffing. The community nursing team was a separate staffing establishment of band five, six or seven nurses. Staff rotated through these services, usually for six-month periods, and community staff supported the unit when needed.
- The trust was part way through a three-year plan to increase NNU staffing to meet 1:1 British Association of Perinatal Medicine standards. Recruitment was ongoing.
- We observed structured and detailed nursing handovers on the NNU and the wards. The wards held nurse-to-nurse handover followed by a team handover led by the nurse in charge. There was a safety checklist completed at the start of every shift. The nurse in charge also held a 9am handover with support staff, including play assistants, teachers and equipment officers. This was to ensure they were aware of any safety and infection control issues, equipment or any other patient needs.
- Nursery nurses took patients to theatre and registered nurses retrieved them from recovery. We observed that at busy times the operating department assistant collected the patient for theatre.

Medical staffing

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- There were 15 paediatric consultants (14.2 WTE) covering a range of subspecialties. They were supported by eight registrars, eight senior house officers and four GP trainees. Data on medical staffing skill mix showed a higher proportion of consultant- and registrar-level doctors than the national average, but there were no middle-career doctors employed. There were 4% junior doctors compared with the 7% England average.
- Medical staffing met The Royal College of Paediatrics and Child Health (RCPCH) guidelines for medical staffing for acute paediatric patients. There were allocated consultants for covering acute services out of hours and weekends in general paediatrics. All paediatric inpatients were seen by a paediatric consultant within 24 hours of admission.
- The junior doctors told us they were well supported by consultants and registrars, including out of hours.
- There was a panel of paediatric-trained anaesthetists and a lead paediatric anaesthetist.
- Surgical junior doctors supported paediatric surgical patients, with paediatrician support as needed. The duty consultant was the named paediatrician for surgical patients.
- The service had two paediatric radiologists and two paediatric ophthalmologists.
- The NNU was staffed by seven consultant neonatologists. There was a RCPCH-compliant medical rota that provided 8am to 11pm consultant presence on the unit and on-call cover. Consultants sometimes covered junior doctor sickness. There was dedicated two tier junior doctor cover on the unit as per the British Association of Perinatal Medicine for level 3 units. No locums were used.
- Medical handover on the paediatric unit was structured around a handover sheet with information about patients updated by the duty doctor before morning and afternoon handovers. There was efficient information sharing, led by the consultant of the day, but with relevant staff contributing as necessary. We observed positive communication and supportive relationships between consultants and junior doctors.
- We observed an afternoon medical handover on the NNU. It was attended by two consultants, a registrar and a senior house officer, with appropriate information sharing and decision making.

Major incident awareness and training

- The service had a major incident plan and a box of instruction cards for staff to follow if activated.
- Fire evacuation drills had been developed with the fire marshal within the fire plan. Another evacuation practice was planned for March 2015.
- There were contingency plans in place to address occasional 'sewage leaks' arising from 'human factors' and the new hospital building.

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.

Care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. This was regularly monitored and reviewed. The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice. Pain was adequately assessed and managed. Consent to treatment was obtained appropriately.

Outcomes of care and treatment were positive and met expectations, when monitored using national and local audits. The outcomes for babies on the neonatal unit were particularly positive when benchmarked against other services.

Staff were appropriately trained and had the skills and knowledge required to undertake their role. They were supported in their role through appraisals and supervision and were encouraged to maintain and further develop their skills and experience.

Services, including access to consultant paediatricians, were provided seven days a week. Multidisciplinary working was very strong within the service and extended to other care groups such as surgery and critical care. It was

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also developing through the implementation of robust processes for transition of young people to adult services. There was good liaison with GPs and community services, and a safer discharge bundle was used by the wards.

Evidence-based care and treatment

- The clinical effectiveness steering group monitored the use of evidence-based care and treatment across the trust. The paediatric unit clinical effectiveness and outcomes report to the steering group detailed participation in national and local audits, monitoring of adherence to National Institute for Health and Care Excellence (NICE) guidance and clinical outcomes.
- The trust review of NICE guidance in paediatrics January 2015, reported the service compliance across technical appraisals, quality standards, as fully compliant most in areas and partial compliance with four quality standards and two clinical guidelines. Action was being taken to address these.
- Clinical guideline folders with latest updates, indexed and dated, were available in clinical areas.
- There was some conflicting information in different documents in relation to the management of paediatric diabetic ketoacidosis (DKA). Staff from the diabetic specialist team told us that the trust had agreed 16–19 year olds with diabetic ketoacidosis would be on the paediatric pathway. This was in response to an incident of a 17-year-old started on the adult pathways who needed to transfer to paediatric intensive care. One paediatric DKA protocol stated it was for those up to 18 years, but the emergency department DKA paediatric protocol was for up to 16 years. In both areas adult DKA guidelines applied to patients over 18 years.
- The paediatric service annual clinical audit report 2014–15 showed participation in relevant national and local audits and peer reviews to check adherence with evidence-based care and treatment. All audits resulted in agreed action plans for improvement and dates for re-audit. The report also detailed improvements already made, including revision of protocols and guidelines. The strategic priorities and audit programmes for 2015–16 included re-audit of other relevant NICE guidance and participation in national audits. The audit report identified the continued development of feedback and improved practice based on learning from audits as a strategic priority.

- The findings and recommendations from audits were presented to multidisciplinary staff at monthly Friday Information and Learning meetings and the presentations were circulated.
- The neonatal service followed evidence-based guidance and undertook an audit programme to check adherence to evidenced-based care and treatment. A summary of the neonatal audit meeting in February 2015, produced for all staff, showed involvement in a range of local and national audits and re-audits. These included trust health records audit; antidepressant use in pregnancy; cranial ultrasound audit; and auditing NICE guideline CG149. The 2015–16 programmes included re-audit of other relevant NICE guidance.
- The minutes showed improvements to practice as a result of audit presented at previous meetings, such as an updated intubation sticker and a new blood culture sticker to document reasons for culturing. Both were observed in use on the unit
- The hospital intensive care unit followed best practice protocols for the care of children and young people. They worked in close liaison with Southampton paediatric intensive care unit and shared protocols for continuity in case of transfers.
- We saw records of action points and learning points from Portsmouth joint critical care meetings, where cases and use of guidelines were reviewed.

Pain relief

- Acute pain management guidelines were available to staff and the acute pain team was available to support the paediatric service. An anaesthetic consultant held bi-weekly pain rounds on the paediatric unit.
- Paediatric pain assessment charts were in use in the nursing documentation we reviewed. Pain relief was reviewed for effectiveness and changed if necessary.
- We observed pain relief was discussed, and a pain assessment chart and information leaflet 'pain relief at home after surgery' were given to parents after children's surgery. This included contact details of the acute pain team if there were any concerns.
- The service had developed a pathway and supporting leaflet for managing pain after tonsillectomy.
- Medication records we reviewed showed clear prescribing of pain relief and the time, route and dose of the medication administered.

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- Monthly audits of medicine management included review of provision and effectiveness of pain relief. Additional training in pain management prescribing for doctors was introduced in response.

Nutrition and hydration

- Meal times were protected, indicated by the ringing of a bell. Clean diets for immune-compromised patients were served first. Food was appetising and checked for temperature before serving.
- There was a two-week rolling menu with an appropriate range of choices, with food made a few hours before the meal. Religious and cultural dietary needs were accommodated.
- On the NNU, neonatal consultants undertook total parenteral nutrition (TPN) prescribing with the support of the neonatal pharmacist. Bespoke TPN was made up for neonates every day and stock TPN was available 24 hours a day, seven days a week.
- A high number of mothers were giving breast milk to babies at six weeks and the service was working to increase the number giving breast milk at discharge.
- Staff in the NNU milk kitchen prepared some feeds for the paediatric unit. Nurses and nursery nurses took responsibility for milk feeds.
- There was dietetic support for both units.
- A guidance and competency assessment booklet was used to train and support parents with tube feeding their babies and children.

Patient outcomes

- The multiple readmission rate July 2013 to June 2014 (1–17 years) for epilepsy was better than the England average. It was worse for diabetes and similar for asthma.
- The non-elective paediatrics readmission rate within two days was worse than the England average.
- The main finding of the national audit of paediatric asthma 2013 was improvements were needed in discharge information. The national audit of pneumonia found the service an outlier for children receiving physiotherapy. Criteria for referral to physiotherapy have since been established.
- National Paediatric Diabetes Audit data 2011/12 reported results just below the national average.

However, local data from the Wessex audit 2014 showed a significant improvement in performance and when adjusted for unit size the service was performing better than average in controlling diabetes.

- The service performed better than the England and Wales average in 19 out of 25 indicators in the patient- and parent-reported experience measure for paediatric diabetes services 2012–13. Since then action had been taken to improve psychologist support for children and young people with poor control of diabetes.
- Action had been taken to address issues raised in the diabetic peer review January 2014. Data from glucose monitors was now downloaded and after a slow start more insulin pumps were in use with improved outcomes for patients.
- The service had participated in and had taken actions to address the findings of Cystic Fibrosis Trust peer review November 2013. The service integrated with Southampton in 2013. Improvements included better access to physiotherapy and increased pharmacy and psychology support. An action plan was in place.
- The service compared favourably with other units in Wessex and the UK in the Epilepsy 12 (RCPCH) national audit. Although the trust was partially compliant overall there were significant improvements in two standards over the year and had 97% patient/carer satisfaction. Work was ongoing against an action plan. The trust was a positive outlier in one standard and more children were seen by an epilepsy nurse specialist compared to the national average.
- In the 2013 National Neonatal Audit Programme (NNAP), the service was meeting or above for all but one standard, first retinopathy of prematurity screening. Results for the 2014 NNAP audit showed improvement with the service meeting, or above, all NNAP standards. The NNU was performing better than all others in the Thames Valley and Wessex neonatal network.
- The service was performing very well in Network NICU outcomes data for survival rates for babies born under 27 weeks. There were good outcomes for pre-term babies born at 23 weeks without surgical problems. Similarly the unit's neonatal mortality rate was low compared with other trusts with the level three neonatal service at fewer than two deaths per 6,000 live births.
- In utero admissions to obstetric services were facilitated to reduce pre-term delivery and had resulted in positive outcomes for babies.

Services for children and young people

- The increase in the use of TPN resulted in good growth rates and data for the period to the end of March 2014 showed the neonatal service was performing well above the regional average on a range of measures.

Competent staff

- All staff working on the unit were paediatric trained. There was agreement that the neonatal medical team would support paediatricians and the ITU team with resuscitation of babies in the paediatric unit, if required.
- The paediatric physiotherapy service was provided by Solent NHS Trust. The reason for not moving the staff to the employ of the hospital was to ensure continuing clinical excellence and professional development in a support network in line with paediatric guidelines.
- Paediatric trained nurses, or adult nurses with additional paediatric training, worked in the theatre recovery areas. Consultants and nursing staff caring for children in critical care/intensive care were trained and had appropriate skills for paediatric intensive care.
- There was an induction programme for nurses on the paediatric unit and a six-month preceptorship for newly qualified nurses. There was a three-day induction programme for staff new to the NNU.
- Junior doctor trainees we spoke with told us their induction was good, with an emphasis on patient safety, and they were able to attend training days because dates were built into the rota. They told us paediatric services were viewed as a good placement in the Wessex training scheme. Junior doctors were monitored and compliant with expected competencies.
- General Medical Council National Training Scheme Survey 2014 trainee doctors within paediatrics rated overall satisfaction with training as similar to other trusts across all criteria. In neonatal medicine overall satisfaction with training was similar apart from local training, which was worse than results for other trusts.
- The training plan for paediatrics included a range of relevant specialist paediatric study days. The trust employed diabetes, epilepsy, respiratory and oncology paediatric specialist nurses. In addition to mandatory training, all nurses attended an annual study day provided by the paediatric specialist nurses. Five nurses were trained in administration of chemotherapy. There were ward link nurses for specialist areas, who attended additional training.
- There was a shared education programme with a local teaching hospital with specialist children's services in Southampton. This supported sharing of best practice and continuity of care for children and young people. Staff attended long-term ventilation training at Southampton.
- A parent of a long-stay patient had recently attended TPN training at a London hospital. They told us they needed to stay overnight because staff were not able to manage the pump and had not had training. We raised this with the head of nursing who clarified that these pumps were specific to that hospital and trust staff were not expected to be trained in their use.
- Staff of all grades were encouraged to develop their competencies and skills through attending study days and feeding back to the team. A nursery nurse undertook additional training for care of tracheostomy care and developed a resource folder and training updates for nursing staff. Another provided in-house training on anorexia protocols following their attendance at study days.
- NNU staff told us they were encouraged and supported to develop their skills and attend relevant study days. There were development programmes for unregistered staff and development of roles in bands one to four.
- The paediatric and neonatal units employed practice educators to support unit-based learning and competency assessment. On the NNU they were developing a list of core competencies and assessments, and annual assessment was undertaken for resuscitation and intravenous drugs.
- Paediatric practice educators ran monthly multidisciplinary simulation training events, to support the development of practical skills and competencies. Attendees included staff from other departments, including intensive therapy unit/critical care.
- The neonatal practice educator also had a mentor support role and intervened early to work with any staff or students needing additional support.
- The neonatal service held weekly junior doctor and consultant teaching, along with Grand Round and Journal Club, to support medical staff development.
- There was a clear focus on appraisal across the service. Trust records April 2013 to March 2014 showed 100% medical appraisal for child health and the NNU. July to October 2014 showed 93% medical appraisals in child health and NNU, and we were told this was 100% at the time of inspection.

Services for children and young people

- Trust records for nursing appraisal showed 95% April 2013 to March 2014, and 93% child health and 87% NNU July to October 2014.

Multidisciplinary working

- There was an appropriate range of multidisciplinary staff providing care and treatment to patients on the paediatric unit and the NNU, including paediatric physiotherapists, pharmacists, dietician, play specialists and school teacher.
- There was evidence of effective multidisciplinary working and handovers on the wards and the NNU. Full multidisciplinary meetings were held every week. A liaison psychiatrist attended handover three times a week and the weekly grand round.
- There was good liaison and working between the neonatal service and colleagues in obstetrics and wider paediatric services. The junior doctor undertook baby checks on the postnatal ward. Babies were brought back for jaundice screening in the children's outpatient department. The postnatal ward midwives administered antibiotics to babies when required.
- There was effective liaison and planning for babies transferring from the NNU to the paediatric wards. Parents were given a tour of the unit and an opportunity to meet staff and a nominated named nurse.
- Paediatric services had positive working relationships with theatres, surgery, anaesthetics and intensive care services. Anaesthetists supported insertion of paediatric PICC (peripherally inserted central catheter) lines. Vascular surgeons inserted and removed Hickman lines. The paediatric resuscitation team was supported by intensive therapy unit medical and nursing staff.
- Two nursery nurses had trained as plaster technicians and supported the children's fracture clinics. Play specialists supported children on the wards and outpatients, and when undergoing surgery or investigations.
- There was nurse-led discharge from the inpatient wards using the Portsmouth safety bundles of discharge checks to ensure all relevant services and teams were informed. The community children's team from Solent NHS Trust supported early discharge of children with complex needs. As part of preparation for discharge, appointed care assistants attended the wards for additional training from ward nursing staff.
- The NNU was proactive in discharge planning and had achieved targets for early discharge; there were discharge planning sisters in post. The community neonatal nursing team supported where required and there was a home oxygen service for babies at 34 weeks. For very high risk and complex babies, the local community NHS trust's paediatric team, physiotherapy and occupational therapists, speech and language therapists were involved at an early stage with overlapping care.
- The community neonatal nursing service worked closely with health visitors.
- Babies were admitted to the NNU under a named consultant. Babies admitted were followed up to the age of two in liaison with the paediatric team if required. Although proactive in discharge planning, babies were kept on the unit until robust and the neonatal service tracked what happened to babies on discharge.
- A paediatric outreach team of nurses, qualified play workers and teachers supported young people on adult wards. There was regular discussion of 16–18 year olds through the Matrons network.
- The diabetes specialist nurses developed a 'schools package' to support best practice in diabetes care.
- The Head of Nursing linked with the Association of Chief Nurses for Children's Services and Wessex-wide services for networking, learning and sharing best practice.
- There was recognition of the need for well-planned transition from paediatric to adult services. A transition policy was in place and from autumn 2014 the service had started implementing a best practice 'Ready Steady Go' programme. Under this programme discussions about transitions started early, at 12 years, so a young person was ready to move to adult services at 18 or 19 years.
- The diabetes service had started weekly transition clinics with adult physicians and the paediatric team.
- There was no evidence of the service monitoring transition or that young people in transition were 'flagged' on the patient administration systems.

Seven-day services

- Paediatric consultant job plans covered weekends. In winter they worked 9am to 6pm on Saturdays and Sundays and in this time were able to do a ward round and manage acute referrals. In summer consultant weekend attendance was from 9am to 3pm for ward round both days and then on-call. This was in line with RCPCH recommendations and current evidence on patient outcomes for summer and winter.

Services for children and young people

- NICU consultants worked 8.30am to 11pm every week day and 8.30am to 4.30pm at weekends, but often worked beyond those hours, routinely returning for evening handover.
- Paediatric pharmacists worked six days a week and the wards had access to on-call pharmacists outside these times.
- Paediatric physiotherapists worked as needed on the wards, including weekends and bank holidays. They were either booked or called in as necessary through the day. There was 24-hour emergency physiotherapy respiratory cover.
- The community neonatal nursing service worked 8am to 5pm Monday to Friday and on a rota to cover at weekends.
- The neonatal transport service operated over a 24-hour period seven days a week.

Access to information

- The wards used joint multidisciplinary records that supported good communication across the team.
- Handover communication sheets, for both medical and nursing staff, were kept on the IT system and so were accessible to all staff,
- There was a log for all yellow and blue card holders (patients with direct access to the children's assessment unit), with clear information about patient details and conditions.
- The NNU had a bespoke electronic records system that supported proactive patient management along with data and performance reports.
- Staff reported good access to laboratory test results and diagnostics through electronic systems.
- Electronic discharge summaries had been developed and ward clerks checked they were emailed to GPs on discharge, or within 48 hours.
- There were some delays in typing and sending fuller discharge letters or outpatient letters to GPs.
- GPs had access to an advice line run by consultant paediatricians Monday by Friday and could phone the unit for information about a child.

Consent

- The consent process was clearly described within the range of information leaflets available to parents and young people. Young people were presumed to be able to give consent depending on their maturity and the

nature of the decision. Staff undertook competency assessment and, when a patient was found not competent, only a person with parental responsibility was able to give consent.

- The patient records we viewed included a record of parental responsibility.
- We observed that parental responsibility was established and recorded at an early stage in assessment. However, on one occasion the triage nurse did not establish verbally if the adult accompanying the child had parental responsibility.
- Consent forms for surgical procedures that we reviewed were fully completed and signed, and included information about risks and benefits of the procedure.

Are services for children and young people caring?

Outstanding



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

We rated caring as outstanding.

All sources of feedback from children, young people and parents about the care and kindness received from staff were continually very positive.

There was a strong family and child focused and caring culture in the service. We found staff were highly motivated to treat children, young people and their families with compassion, kindness, dignity and respect, and found many examples of this.

There were very good relationships, communication and trust between staff and those using services. We saw staff working in partnership and empowering parents, children and young people in their care, particularly those with long term conditions or with a learning disability. Staff actively sought and took account of their needs and preferences, for example they developed patient diaries for those with long term conditions, or who had been in hospital for a long period of time.

Services for children and young people

Staff understood the importance of the social and emotional needs of parents, children and young people, and worked to support them. For example, there was a family support team and fortnightly support groups were held for parents of neonates

Compassionate care

- All staff across paediatric services were very friendly, kind and welcoming to all children, young people and visitors. Some wore badges 'happy to help, just ask'.
- We observed some exceptional staff-child interactions across the services we visited. One example was the operating department assistant's interactions with a child on the way to operating theatre.
- At times during our visits some young children did not have a parent with them on the ward. We observed that, despite being very busy, staff took time to regularly interact, reassure and play with them, positioning their cots close to the door so they could see and hear staff.
- Parents we spoke with were overwhelmingly positive about the care received. For example, "great care by lovely staff, they look after us as a family".
- We observed staff on the neonatal unit (NNU) were compassionate and welcoming to parents, who were made to feel at ease at a very stressful time. Parents told us the care was really good and they would recommend the service. One set of parents was using the service for the second time in two years.
- The services received numerous letters of thanks mentioning the dedicated and caring staff. One parent whose child was seriously unwell and had been an inpatient for four weeks described the staff as an "outstanding team". They said they were happy to leave their child with them overnight because they were responsive and caring like a family.
- Another feedback letter commented "the team worked tirelessly and extremely well together to deliver an outstanding, professional and caring service and fulfilled every one of your trust's values".
- The paediatric performance dashboard recorded an average of 34 plaudits a month over 2014; 40 plaudits had been received in November 2014.
- The Starfish ward team had recently won Best People awards in recognition of the care provided to a child and their family.

- Parent surveys had consistently high levels of satisfaction at 95% and above. We saw feedback from children and young people included positive comments about staff, such as "nurses lovely and caring" and 'doctors friendly, listening and kind'.
- Comments from the NNU Parent Feedback survey January 2015 included "All staff were amazing, compassionate and always giving reassurance" and "Very, very impressed by the service, they took really good care of our baby".

Understanding and involvement of patients and those close to them

- We observed clinicians communicating very well with, and listening to, children, young people and their parents. They were responsive to all questions and asked parents' views.
- Parents and families we spoke with were fully informed and involved in care. Parents felt in control and were taught aspects of care to support their child. Care records clearly detailed joint decisions between parents and staff.
- Young people in specialist services told us that staff spoke with them and considered their views.
- Play workers and operating department practitioners were involved in the pre-surgical assessment. Photo journey books were used to help explain the process to children.
- Parents or family members were encouraged to accompany children to surgery, from the ward and into the anaesthetic room. They met them in the recovery room, when they woke from anaesthetic and accompanied them back to the ward.
- A parent of a surgical patient commented in a feedback letter "Everything was explained to us and we were made to feel at ease about the whole procedure"; they added, "All the staff we came into contact with were fantastic and made our hospital experience a good one".
- Another stated "communication was excellent with reasons/options re testing/treatment fully explained with plenty of opportunity for questioning/concerns afforded and sensitively addressed".
- Staff used 'young person and family communication diaries', particularly for children and young people who were long stay patients or had long term conditions. Key information was recorded and parents could write questions and comments, and get a response.

Services for children and young people

- A parent of a child with a learning disability told us that she had built trust and respect with the paediatric team over time. She felt she was taken seriously as an 'expert' on her child, and that staff responded if she had any worries or concerns.
- Parents on the NNU told us they were kept informed of their baby's progress from day one and staff listened to their suggestions. They were involved in discharge plans and had been to visit the children's assessment unit.
- There were positive responses to questions about involvement in baby's care in the NNU Parent Feedback survey, January 2015. Comments such as "The doctors kept us well informed at all times of what was happening. The nurses told us everything and kept us informed of any changes" and "I was told I was welcome to phone at any time I wanted, this reassured me greatly".

Emotional support

- Psychology services were available for children and young people living with long-term conditions and receiving specialist services.
- The staff were concerned that oncology children were isolated because they were nursed in side rooms. The staff therefore provided specific emotional support. We saw examples of staff providing emotional support to an oncology patient who had suffered bereavement.
- Children, young people and their parents were positive about the emotional support provided by specialist nurses.
- Parents on the NNU were positive about the family support they received.
- Comments in the NNU Parent Feedback survey January 2015 were positive about the support available, including "While I didn't speak to them, I was aware of a family support team if I needed them. Head nurse very supportive and informative".
- The NNU held fortnightly parent group meetings and sessions covered a range of supportive topics. The topic 'Emotions on NICU' facilitated by a family support councillor was added to the programme in response to feedback on the 2014 sessions.

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 a purpose-built paediatric unit and original plans included a ward for teenagers and adolescents. This ward was now used by another service. Most young people aged over 16 years were admitted to adult wards and the trust was supporting and monitoring delivery of care to meet their needs. The paediatric unit now admitted young people up to the age of 16 years only, with exceptions for those aged 16 to 19 who would benefit from continuing under the care of paediatric team and/or chose to do so. Facilities for teenagers on the unit were limited and they were sometimes cared for in bays with children and babies of all ages.

There was no designated high dependency area. The high dependency unit in the original plans was found to be too small, so these patients were spread across the medical ward.

There was no single point of access for emergency care; the children's emergency department and children's assessment unit (CAU) had different roles in the pathway, which was not always clear or efficient. We heard of parents and children waiting in the emergency department before being transferred to the CAU and waiting again before admission to a ward. Children and young people with long-term conditions who were known to the service had direct access to the CAU.

A primary care liaison service was being piloted in response to increased attendances at the CAU. This provided advice and support to GPs and primary care staff, and facilitated access to appropriate care and avoided unnecessary admissions.

The service ensured that nationally set waiting times were met for outpatients, cancer services, surgical procedures and other treatments.

The service was responsive and made adjustments to meet the needs of children with a learning disability, and their parents. There was timely access to acute mental health

Services for children and young people

services and the unit was supported by a visiting liaison psychiatrist. But access to psychological and counselling support was limited, unless part of a long-term conditions pathway.

Complaints were taken seriously and were investigated and where necessary changes in practice occurred.

Service planning and delivery to meet the needs of local people

- The service moved from another site to the purpose-built units within the new hospital in 2009. The original plans for the paediatric unit had included a ward for teenagers and young people up to the age of 18 years. The intended ward was currently used for gynaecological services. The planning of services for young people aged 16–18 years now focused on delivery of services to meet their needs on the relevant speciality adult wards. This was overseen and monitored by the Paediatric (C&YP) Standards and Quality Committee.
- The paediatric unit and wider hospital had been audited against 'You're Welcome' standards and action plans were monitored by the Paediatric (C&YP) Standards and Quality Committee.
- The service had liaised with adult specialities and developed a standard operating procedure to take account of the needs and choices of young people and to support patient-centred care. The procedure and a supporting checklist were still in the process of implementation across the hospital at the time of inspection.
- We visited some adult wards. Young people on orthopaedic adult wards were offered a side room and parents were able to stay if they wanted. Young people who were acutely ill when admitted, for example with acute tonsillitis or quinsy, were nursed in a bay so they could be observed. Staff described how they took care where they were placed to take account of their needs, and provided flexible visiting times. The private ward accepted children aged 15 if a parent stayed with them.
- Staff on one adult ward told us they were using charitable funds to buy electronic gadgets for young people.
- Young people aged 16–19 with diabetes admitted to adult wards were supported by the adult team. The adult lead diabetic consultant was innovative in giving young people a mobile phone for communicating with the service by texts, emails, Twitter and social networking.
- The service had completed the '15 step challenge' to check the suitability of the environment and signage and found this did not meet the standards for 17-year-olds.
- There was recognition of the need for service developments to address the lack of a designated high dependency unit and young people's area in the paediatric unit.
- The planned high dependency unit room was converted to be used for cots only. Higher dependency patients were spread across the medical ward and not in a defined area. The service had started collecting data on the number of higher dependency patients being admitted and was participating in a regional high dependency audit. This was part of RCPCH efforts to improve consistency and quality of high dependency unit care nationally.
- Teenagers sometimes were cared for in bays mixed with children and babies of all ages. There were limited facilities for teenagers and young people on the unit. Each ward had a very small teenager area around a desk in the corridor and there was no internet access. We were told that the newly appointed director of nursing was expected to lead on service planning for an adolescent ward or designated area within the paediatric unit, and commissioners were supportive.
- There had been an increase in the number of children admitted with long-term complex needs. The head of nursing was in discussion with the commissioners and contracts department to review arrangements for the child's care assistants at home to accompany them into hospital and support their care, thus providing continuity for the child.
- The CAU's emergency activity had been increasing year on year. Various projects had been piloted with agreement of commissioners. A six-month project employing two advanced nurse practitioners on CAU was not cost effective. The service now employed one advanced nurse practitioners working across the children's emergency department (ED) and CAU. This was judged to be working very well, with plans to increase advanced nurse practitioners numbers in liaison with the ED.

Services for children and young people

- In September 2014 the service started a 12-month pilot of a consultant paediatrician liaison service for primary care. The service operated 10am to 3pm Monday to Thursday and 10am to 1pm on Fridays for taking and triaging admission calls, and manning a consultant advice line. The service enabled immediate access to dedicated consultant advice and guidance as the first point of contact for primary care. To date feedback was positive. The service had provided support and education, and facilitated access to appropriate care and avoided unnecessary admissions.
- The outpatient cannulation/venepuncture team provided a Monday to Friday service for GP patients.
- Most services for children were provided in designated paediatric areas, such as children's operating theatre and recovery room. Orthopaedics used a different theatre but children were first on the list.
- The majority of children and young people attended outpatient clinics within the paediatric unit. Rheumatology clinics were due to move to the paediatric outpatients department. The ENT department ran dedicated paediatric sessions in the ENT department. There was an adolescent waiting area in the children's outpatients department.
- Visiting specialists provided clinics to meet local need and there was joint planning with Southampton Hospital on the delivery of services.
- The NNU had submitted a business case for a 24-hour ward clerk to cover answering the phone and front door out of hours. They had recognised that nurses were covering this role, taking them away from patient care, and were not providing a timely service to callers.
- The trust had representation on the Portsmouth City Council – Children's Trust Board Meetings and minutes fed in to the Paediatric (C&YP) Standards and Quality Committee.
- Staff described a procedure for ambulances to go straight to the CAU, bypassing the ED. A document, 'Pathways for self-referred 999 paediatric patients', stated that the CAU accepted medical patients up to the age of 16. The children's ED accepted trauma (and overdose) and patients actively receiving cardio pulmonary resuscitation, except newborns who went to the CAU following a pre-alert.
- There was written guidance for staff on 'what to accept on CAU' and 'do not accept on CAU'. Over 16-year-olds were not accepted on the CAU unless they had a valid yellow or blue card 'passport' to the unit, or had taken an overdose and were still at school and/or known to the Child and adolescent mental health services (CAMHS). The guidance on overdose appeared to contradict the pathway document above.
- The yellow card system facilitated direct access to the paediatric unit for children and young people known to the service. For example, patients with diabetes, once diagnosed, were given a yellow card.
- We were told that children over five years old with abdominal pain were seen first by surgeons in the children's ED, then referred to the CAU if non-surgical. All potential surgical cases aged under five were seen in the CAU to ensure they were medically stable before transfer to Southampton hospital paediatric surgery service.
- All medical cases were seen in the CAU so self-attenders to ED could wait some time before being transferred.
- Two families we spoke with on the ward described how they had attended the children's ED and after waiting some time were directed to the CAU, where they waited again for assessment and admission. One child, who had arrived in the morning, had waited until 8.30pm for admission.
- Patients were prioritised in the CAU according to clinical need, and potential discharges were identified to maximise patient flow. The service reported 41% of attendances were discharged home within four hours over the year 2013/14. Of the remainder, 72% were admitted to the wards (A7 or A8) and stayed on average for 1.5 days. The CAU did not monitor or report on urgent care four-hour targets, but was seen as an outpatient service.
- The bleep holder's folder contained escalation plans for covering bed shortages. Paediatric 'flex beds' were identified on the gynaecology ward, within the unit, but at the time of inspection these were filled with medical outliers.

Access and flow

- There was no single point of access to paediatric services. There were several different pathway documents describing access to paediatric services through the children's ED or CAU, but there was no clarity and the process was not always seamless.
- We were given a copy of 'Portsmouth area emergency ambulance directive for children', which was out of date because it referred to the previous site of paediatric services at St Mary's Hospital.

Services for children and young people

- The trust guidance was clear that the CAU never closed. During the second day of our inspection there was a shortage of beds on Shipwreck ward for surgical day patients so some inpatients moved to the four-bedded bay on the CAU. Three operations were cancelled and all patients were offered new dates within two weeks.
- The trust-wide system for managing outpatient waiting lists changed in September 2013 to improve the management of follow-up appointments. There was a reduction in 'did not attend' rates for follow-ups to 13% but a slight increase in 'did not attend' rates for new appointments to 9%.
- Waiting times for appointments were monitored, and under the new system paediatricians were informed when there was build-up of patients waiting. To ensure a responsive service, paediatricians provided additional clinics for these patients, outside their agreed work plans.
- Pre-operative assessment was undertaken two weeks before surgery. This was face to face or by telephone, depending on complexity, parent choice, child anxiety and if previous surgery had been undertaken.
- The service had met referral-to-treatment and cancer targets.

Meeting people's individual needs

- The paediatric unit was for children and young people up to 16 years, but exceptions were made according to individual need. A blue card facilitated access to young people over 16 years who were known to the service and chose to attend the unit rather than adult services. Young people with diabetes and other chronic health needs, for example cystic fibrosis, cancer and inflammatory bowel disease, who remained under a paediatrician, were admitted to the paediatric unit. For example, a 19-year-old oncology patient who had palliative care needs preferred to stay on the unit for symptom control.
- Young people with a severe learning disability under the care of paediatricians were looked after in the paediatric unit up to the age of 19 and were given a 'blue card' offering them a choice of admission to paediatrics or a hospital passport/care plan.
- The learning disability liaison team was available to support staff to meet the needs of children and young

people with a learning disability. The learning disability nurse had provided some training to the team and the learning was disseminated through the Friday information and learning meeting.

- A learning disability communication book was available for staff to use with children and young people with a learning disability who were attending outpatient clinics.
- Trust-wide groups had been set up to consider the needs of patients with a learning disability. Adjustments were made for children and young people with a learning disability who needed surgery by providing additional pre-operative planning with play workers and prioritising them on surgical lists.
- Adjustments had been made for children and young people with a learning disability to have MRI scans under general anaesthetic.
- In addition to the visiting liaison psychiatrist, there was a clear referral process for mental health assessment of children and young people admitted to the CAU, for example those presenting with self-harm. CAMHS attended for same-day assessment of mental health needs if referral was made before 10am. Staff reported the service was responsive for acute referrals but there were longer waits for more routine referrals.
- Staff told us there were delays in discharges from wards if transfers to CAMHS inpatient services were needed.
- Psychologist support for inpatients was limited and not widely available unless a patient was on a long-term condition pathway. We were told that non-acute CAMHS support and counselling was not easily accessible because thresholds for access had changed.
- There was increased psychologist support for children and young people with diabetes, and their families, who were finding it difficult to manage their condition.
- For palliative care neonates, children and young people, there was discussion with parents about going home and there was liaison with GPs, health visitors and the palliative community team to support this.
- Staff were concerned that when the ward was short-staffed they did not have the time to support the emotional and social needs of young oncology patients, who could become isolated in side rooms.
- The diabetes team had not been able to take children with diabetes on holiday in 2014 because of staff shortages, but was committed to running the holidays in 2015 as staffing increased.

Services for children and young people

- The language line was used and there was access to interpreters. We were told that staff did not use members of the family as interpreters. Language identification charts were available to guide staff on which interpreter was needed.
- There were a wide range of information leaflets on common illnesses and conditions. There was also guidance information for parents to support their involvement in care. The NNU used information leaflets, many produced by the charity BLISS, to support parents' understanding and involvement in the care and treatment of their babies.

Learning from complaints and concerns

- There was guidance about how to raise concerns or complaints in all the patient and parent information leaflets.
- The service had received a complaint in relation to a complex neonate and had undertaken a full investigation and identification of lessons learnt. The service responded with additional teaching and guidance for staff.
- There was a clear pathway for staff to follow if concerns and complaints were raised, with an emphasis on face-to-face meetings to respond to and resolve issues at an early stage.
- Staff training was provided in the prevention and management of complaints, and this included supporting staff to develop skills in encouraging people to raise concerns.
- The service had recently introduced a leaflet in response to a clinical incident and parents trying to raise a concern about their child but not feeling listened to. The leaflet 'what to do if you are worried about your child in hospital' was seen at all bedsides in the paediatric unit. Roll out to adult areas of the hospital was planned.
- Parents told us they were happy to escalate any concerns and that staff, and especially ward sisters, were very responsive.
- Complaints were monitored monthly and associated learning was discussed at governance meetings to ensure that actions required were being implemented.
- Feedback from children, young people and parents was actively sought through a range of surveys. Action was taken in response. For example, following feedback from parents, staff now all wore different-coloured name badges with a simplified description of their role, which were linked to staff photo boards.

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.

There was a clear statement of vision and values underpinned by quality and safety. Staff understood and were committed to the vision and demonstrated this in their work. The service measured itself against trust strategic priorities and had also identified service-level strategic ambitions and priorities. These included improving the responsiveness of the service. The leadership understood the challenges to achieving these and discussions with stakeholders were ongoing. But detailed plans to support the strategic aims were still in development.

There was a culture of continual learning and improvement, which was supported by strong leadership and multidisciplinary team working. Risks and quality were monitored at all levels, with action taken and changes made when needed.

There was good communication and engagement with staff and innovation was encouraged. Children and young people and their parents were encouraged to provide feedback and ideas for improving the service. The service had embraced the trust-wide initiative of 'listening into action'.

Staff development was both supported and actively encouraged for succession planning and building a sustainable service for the future.

Vision and strategy for this service

- There was a service-wide vision based on the best care, best people and best performance. The paediatric unit had a clear vision statement, 'a dedicated, professional and friendly team putting high quality care of children and families at the heart of everything we do'.

Services for children and young people

- The neonatal unit had a vision of an exemplary unit within the trust, a tertiary service within a district general hospital. There was a plan to have more high dependency unit (HDU) cots to accommodate the increasing numbers of level 2 babies. This will enable the neonatal unit (NNU) to take more babies through the unit. The NNU team had received financial support for expansion of nurse staffing levels.
- Staff at all levels were clearly aware of and committed to the vision, aims and objectives of the services.
- The trust-wide clinical services strategy identified key strategic developments for the service over the next three years. These included: expansion of the community children's team 'COAST' integrated care partnership with primary care and Solent NHS trust; creation of an integrated paediatric emergency service, better integrated with the trust's overall emergency care pathway and accommodating HDU patients on the wards; potential repatriation of allergy and sleep study patients. Some of these were issues that were impacting on the responsiveness of the service.
- There was recognition of the need to work collaboratively with internal and external stakeholders, but clear plans with timescales to support the strategic ambition and service developments had not yet been developed.
- The service has been in consultation with commissioners who were supportive of a single pathway for admission of medical and surgical children and young people. Plans to move the CAU adjacent to the ED had not progressed because of issues relating to cost, site and staffing. The ED service had been considering direct admission from the ED to the wards if patients were triaged and treated.
- Some staff were aware of discussions about strategic issues that needed to be addressed and had ideas for future improvements, but had not been involved to date.
- The paediatric medication group and local working groups reported to the paediatric unit governance meeting. This and the neonatal governance group reported into the women and children's clinical service centre (CSC) governance committee.
- Alongside this, hospital-wide clinical services and the paediatric surgical forum submitted governance reports to the paediatric (C&YP) standards and quality committee. This committee had responsibility for overseeing quality and performance of services for children and young people across the hospital. The committee was chaired by the chief executive officer (CEO) who was board lead for children and young people's services. The committee monitored peer reviews, audits and action plans. Hospital-wide CSCs submitted governance reports to the committee on quality of services for children and young people. There was also a network of paediatric link representatives from across the hospital to support best practice in the care of young people in all departments and wards.
- Both the paediatric (C&YP) standards and quality committee and the CSC governance committee reported into the trust governance and quality committee, which reported to the Board.
- The risks associated with increased numbers of HDU patients had been identified and were being monitored through the regional audit. The lack of adolescent ward or designated area within the paediatric unit, and the need for further action to address the issues, was recognised.
- At service level there were a range of quality initiatives. A consultant and senior nurse undertook monthly patient safety walkabouts.
- The Portsmouth quality bundle was on display in all areas. It included monitoring information on plaudits, incidents, complaints, staffing levels for the number of high care patients, sickness, and medication errors.
- Local clinical working groups reviewed clinical and safety issues.
- The service monitored its performance against the trust's key objectives and evidence to support progress and achievements was collated.
- The Portsmouth paediatric unit dashboard, with red-amber-green ratings, was used to monitor a range of performance, quality and risk indicators under the categories of: activity, workforce, clinical, and safety. Nursing staffing vacancies were amber flagged, sickness levels were red flagged.

Governance, risk management and quality measurement

- There was a governance structure and mechanisms for measuring quality and escalating risk within paediatric and neonatal services.

Services for children and young people

- Detailed risk registers were maintained, showing progress month on month. The paediatric unit risk register included environmental, health and safety, equipment and clinical risks. There were clear action plans which were regularly updated, and some risks had been appropriately removed or closed following actions.

Leadership of service

- The service was well led, with strong visible clinical leadership in the paediatric and neonatal services, supporting cohesive team working and effective patient care.
- The senior ward sisters and the band six 'bleep holder' had a good overview across the paediatric unit and supported the ward team.
- The nurse in charge of shift wore a badge to make them clearly identifiable, and they had a clear pivotal role in the day-to-day leadership of the wards. This was more difficult on the occasions when, because of staffing shortages, they were allocated patients to care for.
- There was a matron covering both paediatrics and gynaecology, and ward sisters found her supportive but that she spent a lot of time in the gynaecology wards.
- Senior staff in the paediatric and neonatal service had completed the NHS leadership framework. All the wards/units in the service had achieved gold accreditation following assessment against the trust's supervisory leadership nursing framework.
- Junior staff felt very supported by senior ward sisters and senior managers who were visible and approachable.
- Staff told us that the trust senior management team, in particular the head of nursing, was available and responsive to the needs of the service. The CEO was visible in the service, approachable, and staff felt willing to raise issues with her directly. Staff felt she had a good understanding of issues and peer review reports about the service.

Culture within the service

- The service had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families.

- Staff at all levels felt valued and were proud of the service, patient outcomes and parent feedback. They felt supported to provide high-quality care. Ward clerks, teachers, play workers, nursery nurses and other support workers all felt part of one team.
- There were very positive working relationships and cohesive team working between nursing and medical and allied healthcare professionals, built on mutual respect. All had clear roles and accountabilities and were focused on working towards high-quality patient care. For example all had signed up to 'paediatric inpatient ward expectations' and ward round rules.
- We found a culture of multidisciplinary learning and development and positive team work across the service. All staff told us that the thing they were most proud of was team work.

Public and staff engagement

- Children and young people were involved in the 15 steps challenge, 'quality from a patient's perspective', undertaken in December 2014 and January 2015.
- A 'pants and tops' system was used to encourage children and young people to write feedback on what they liked and what they didn't like about the paediatric wards.
- There were young person's and children's surveys that were age appropriate and used to gain feedback.
- Children and young people were asked to comment on their experience of the paediatric diagnostic imaging service using Thumbs up or Thumbs down tokens.
- Parents' views on ideas for improvements were actively sought. There were regular surveys and opportunities for feedback. Parents evening were held twice a year for information sharing and feedback. A parent representative attended NNU clinical governance meetings.
- There were regular parent meetings and surveys on the NNU and changes to facilities for parents made as a result. The neonatal network was purchasing an app to support wider feedback from parents.
- The service was planning to introduce the NHS Friends and Family Test in April 2015.
- Staff had taken part in the trust-wide 'listening into action' initiative; an example of an action arising from this was making changes to staff badges based on what they had heard.







Services for children and young people

- Staff on the NNU told us there was good communication and they were well informed and referred to noticeboards.
- The service used staff surveys to gain anonymous feedback and make improvements. Staff told us they were asked for ideas and there was a suggestions box in the staff room. There were regular ward team meetings and sisters meetings for two-way communication.
- All were encouraged to attend monthly Friday information and learning meetings and there was monthly feedback to staff on what had been learnt.
- Senior managers were aware of staff concerns relating to an increasing acuity among children admitted to the unit; lack of dedicated HDU area; and poor facilities for young people aged 13–16 years. It was not clear that staff were involved in suggesting improvements or that practical interim steps were being taken to address these issues.
- The service was actively involved in workforce development and planning for the future, for example developing a career framework for band five and six nurses.
- There was a new initiative of a talent panel, a mechanism to discover and develop staff both for individual career development and the future sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified. For example a band three member of staff was supported into a band four role providing tracheostomy training and resources to the wider team.
- The neonatal team were proud of the succession planning, recruiting and training of staff, to address the potential challenge of a significant number of nurses retiring over the next five years.
- The paediatric team had a growing research programme; there were 13 active studies in 2014 and six paediatric consultants were principle investigators for studies.

Innovation, improvement and sustainability

- There were a range of recognition awards to promote innovation and improvement. Teams in the service had won trust-wide Best People awards in recognition of care provided. Staff from the service were regularly nominated and awarded Extra Mile Awards. A dietician won an innovation award for a teaching package for diabetes.
- The service had found non-recurring savings but was still to find recurring cost improvement savings. Most of the service budget related to staffing costs and we were told that the trust understood this. The service felt there was a general acceptance that paediatric services were cost efficient and effective.
- The NNU employed nurses who undertook research roles in addition to their clinical work; they told us about numerous research opportunities. The unit was participating in the Neonatal and Paediatric Pharmacokinetics of Antibiotics (NAPPA) study.
- The NNU participated in international quality improvement projects such as the Vermont Oxford Network, which aimed to improve the quality and safety of medical care.
- Through innovation, and with support from the trust, the neonatal service had been successful in securing the contract to provide a regional neonatal transport team for transporting babies requiring specialist treatment and services.

End of life care

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

Information about the service

Patients at the hospital with end of life needs are cared for on the general wards. They are supported by a consultant-led hospital palliative care team and an end of life care team. Palliative care is part of supportive care that is provided generally to patients with cancer and other medical conditions (patients with non-malignant disease) who are at the advance stage of their disease and need help in managing their pain.

This hospital palliative care team is a specialist provider of advice on pain, and supports training and education in palliative care across the trust as requested and in the local hospice. It comprises one consultant (1.0 whole time equivalent (WTE) and four palliative care clinical nurse specialists (3.6 WTE)). During April 2013 to March 2014, 2,200 patients died in the trust.

The end of life care team supported staff on the wards to provide care for patients who are at the end of their lives. This team comprises three clinical nurse specialists. The two teams (the end of life care team and the hospital palliative care team) work across all of the adult wards in the QA Hospital. One team provides a specialist advisory service in palliative care; the other provides ward support for dying patients.

Most individual wards have end of life care link nurses who act as champions. They take on additional training for this role and are given time to attend meetings and training sessions. Both teams are well supported by the bereavement support staff, the chaplaincy team and the mortuary staff.

During the inspection we visited the acute medical unit, the renal wards, the care of elderly wards, general medical wards, the oncology wards, general surgery and orthopaedic wards, the bereavement office, the mortuary, and the chapel. We spoke with 12 patients, 14 relatives, three friends of patients, 28 nurses, four clinical nurse specialists, seven consultants, 12 healthcare assistants, seven ward sisters, four matrons, two managers, five domestic staff and eight volunteers. We also spoke with three mortuary staff, four members of the chaplaincy team and four chaplaincy assistants.

End of life care

Summary of findings

Nurse staffing levels in some ward areas meant that the personal care needs of patients receiving end of life care were not always being met. The trust needed to improve the medical staffing levels, in particular consultant staffing for palliative and end of life care, to be in line with national recommendations. Nursing staff did not always undertake the appropriate safety checks on syringe drivers when these were being used by patients. Pressure-relieving air mattress were not always available for patients when required and this therefore increased the risk of patients developing pressure ulcers.

The trust had one standard form for 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, which was introduced in 2014. However, some ward areas still retained and used old forms and these did not include any guidance for completion. The trust DNACPR audits demonstrated gaps in completion, but there had been improvements. During our inspection, however, we found some forms were not completed according to national guidelines.

Staff reported incidents on the trust-wide electronic reporting system. They also received feedback from concerns and incidents reported. Staff had a good understanding of safeguarding. Medicines were appropriately managed and staff followed infection control procedures.

Following the withdrawal of the Liverpool Care Pathway in July 2014, the trust was piloting new care plans for end of life care on four wards. These were completed to an acceptable standard. However, where these care plans were not used, the documentation of care was not sufficient to properly assess and make decisions about patient care. We found some staff were not aware of end of life care principles and there was a reluctance to make end of life care decisions.

The AMBER care bundle was an approach used in hospital when doctors were uncertain whether a patient may recover. Generally, it was initiated when patients had a few months to live. The roll out of the AMBER care bundle had been kept to a limited number of wards to ensure its effectiveness due to the sensitivity of the

removal of the Liverpool Care Pathway, and to avoid confusion during the introduction of the Wessex wide Achieving Priorities of Care (APoC). Most patients received appropriate pain relief and had appropriate nutrition and hydration.

The trust only partially participated in the National Care of the Dying Audit – Hospitals 2013/14 and because of this was not able to compare its' performance with other trusts. For the organisational key performance indicators, the trust scored better or the same for five out of seven indicators. Local audits demonstrated some progress with clinical and organisational performance indicators.

Both the hospital palliative care team staff and end of life care team were supported to develop their knowledge and competencies. The hospital had strong links with the local hospice. While the organisation was not part of the trust, it worked closely with the palliative care physician. The end of life care support team provided a seven-day service over specific hours. The hospital had access to 24-hour palliative medicine consultant advice 365 days a year.

During our inspection we observed staff were compassionate and caring and treated patients with dignity and respect. Families told us they were well informed about the condition of their relatives.

Services were being planned and delivered to meet the needs of the local population. For example, the trust had introduced a seven-day service on the ward by the end of life care team and was planning to merge the palliative care and end of life care teams to provide a more seamless service. Information was being used to improve awareness of the service across the trust so that patients were appropriately referred to the teams.

Most patients were being seen within 24 hours of referral to the teams. Many patient requiring end of life care were treated in side rooms. There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than the national average.

The leadership team had developed a draft revised strategy for end of life care that took into account national guidance and reports on improving end of life

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care. The strategy outlined initiatives to improve and monitor the quality of care, care coordination, the culture of care in the trust and working with community teams. The leadership was knowledgeable about quality issues and priorities. Senior staff members took appropriate action to address these issues. There was a culture of responsibility between the end of life care team and the palliative care team. However, risks needed to be better identified, assessed and managed.

The trust had a 'listening into action' initiative that enabled staff to provide solutions to common challenges for end of life care in the trust. Patients and their relatives were to be consulted on the strategy and the relatives of bereaved patients had been surveyed to improve the service. There were innovations in practice, which included integrated care and trained volunteers to support patients.

Are end of life care services safe?

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

We rated safe as requires improvement.

Nurse staffing levels in some ward areas meant that the personal care needs of patients receiving end of life care were not always being met. The trust also needed to improve the medical staffing levels, in particular to ensure consultant staffing for palliative and end of life care was in line with national recommendations. Nursing staff were not always undertaking appropriate safety checks on syringe drivers when these were being used by patients. Pressure-relieving air mattress were not always available for patients when required and this therefore increased the risk of patients developing pressure ulcers.

Some patient records were not stored securely and could therefore be accessed by unauthorised personnel. The trust was piloting new care plans for end of life care on four wards and they were completed to an acceptable standard. However, where these care plans were not used, the documentation of care was not appropriate to properly assess and make decisions about patient care.

The trust had one standard form for a 'do not attempt cardiopulmonary resuscitation' (DNACPR) decision, which was introduced in 2014. However, some ward areas still retained and used old forms and these did not include any guidance for completion. The trust DNACPR audits demonstrated gaps in completion but there had been improvements. During our inspection, however, we found some forms were not completed according to national guidelines.

Staff reported incidents on the trust-wide electronic reporting system. They also received feedback from concerns and incidents reported. Staff were aware of the duty of candour principles. Medicines were appropriately managed and staff followed infection control procedures.

Staff had been trained in safeguarding and both the hospital palliative care team and the end of life care team had completed all their training.

Incident reporting, learning and improvement

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- The end of life care nurses and the palliative care nurses were aware of their responsibilities to report incidents and reported incidents using the hospital's electronic system.
- Incidents and actions taken were also discussed at weekly multidisciplinary team meetings.
- Staff were able to give us examples of where practice had changed as a result of an incident. For example, there had been an incident where the information for a patient receiving mouth care was not recorded in the notes. As a result, new documentation for recording mouth care was implemented and rolled out across the organisation.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS.
- The duty of candour was discussed at an end of life care steering group meeting. The discussion was led by the consultant in palliative care who outlined its origins and importance to patients and relatives.
- Staff we spoke with had an understanding of the duty of candour. While most staff had not received any formal training on this, there was guidance and information available to them on the intranet.

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.
- Mortuary staff explained the trust's infection prevention and control policy and the procedure for the care of the deceased. There were zipped cadaver bags, allocated fridges and a post-mortem room available in the mortuary for deceased persons who had notifiable infections, to prevent the spread of infection.
- Palliative care team and end of life care team were aware of their roles and responsibilities with regard to infection control. They wore clean uniforms and were

'bare below elbow' in clinical areas. Staff had access to personal protective equipment and we saw they used these appropriately. We also observed staff washing their hands after attending to patients.

Medicines

- Staff follow the medicines policy and managed controlled drugs in accordance with the Controlled Drugs Regulation 2013.
- 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 with these medicines. An audit had recently been undertaken and found that 70% of the patients had received anticipatory medicines. Nursing staff also received training on the use of anticipatory medicines.

Environment and equipment

- The National Patient Safety Agency recommended during 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. The Graseby syringe driver had been withdrawn from the hospital and the majority of nursing staff throughout the trust had been retrained to use the McKinley syringe driver.
- Most staff were aware of how to use syringe drivers effectively and safely. Training for this was provided to relevant staff on a regular basis. Records for this training were kept with the ward sister. However, we found on four different wards (E3, G2, G4 and F4) that staff did not have a full understanding of safety checks they needed to undertake when a patient was on a syringe driver. Safety checks were not being done according to the trust's policy. This could put patients at risk of not receiving the medication they required at the correct rate and quantities.
- Patients were equipped with call bells in order to attract the attention of a member of staff when necessary.
- Equipment was regularly maintained and checked to ensure it was safe to use. However, staff told us they did not have any problems obtaining syringe drivers for end of life care patients. The hospital also did not have enough pressure-relieving air mattresses for patients who required them. On the day of our inspection there were 20 patients who required this special mattress but the trust could not make them available. Staff from the medical equipment library told us the wards had this

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equipment but had not returned it to the library after patient use. The equipment was often left in the corridors on the wards and porters had to go throughout the trust to get the equipment back to the library. The unavailability of this equipment posed a significant risk to patient safety because patients could develop pressure ulcers.

- Equipment used in the mortuary was maintained and checked regularly. Records demonstrated that the trolleys and refrigeration system were checked weekly by the mortuary staff and annually by the external contractors.
- There were contingency plans for bariatric patients. Mortuary staff had received appropriate training to store deceased bariatric patients. Porters had received specialist training in moving a bariatric patient from the ward.

Records

- In some ward areas we inspected, we saw some records were placed on the top of trolleys in ward corridors. The records were not stored securely and could be accessed by people who did not have the authority to do so, thus affecting patient confidentiality.
- The trust had introduced a new end of life care plan (called Achieving Priorities of Care) in August 2014; it was used on four wards as a pilot (one care of elderly and three oncology wards). This was in response to the national withdrawal of the Liverpool Care Pathway in July 2014. The new documents were to be used in the last days or hours of a person's life. These have been well received by the nursing staff and were filled appropriately. The feedback from this pilot had resulted in a revised end of life care plan that would be rolled out across the trust in summer 2015. These new care plans were more comprehensive and detailed so as to enable proper recording of information. With these new care plans it was expected that all healthcare professionals treating end of life care patients would be able to readily access information.
- For wards where the new care plans had not been introduced, the documentation of end of life care was not as clear. Information was recorded in the notes in separate sections, making it difficult to assess how best to take care of the patient. 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 had one standard form for resuscitation decisions introduced in 2014. However, we found previous versions of forms still on the wards. The old forms did not have guidance on how to complete it. Without this guidance, there was greater likelihood the form would not be filled out as required. Furthermore, some ward staff were not aware that the form had been updated to include guidance. In almost all cases, the DNACPR form was at the front of the notes, allowing easy access in an emergency.
- The trust carried out regular audits of DNACPR forms and the data compared over three audits cycles, in 2011, in 2012 and the most recent audit October 2014. All three audits looked at 40 forms. Since the previous DNACPR audit in July 2012 there had been significant improvement in the number of decisions being discussed with patients (from 58% in 2012 to 70% in 2014) and in documentation of the reasons cardiopulmonary resuscitation (CPR) was considered likely to be unsuccessful (from 94.4% in 2012 to 100% in 2014). There was an improvement in the number of forms being verified by a consultant within a 48-hour period, from 81% to 88%.
- We inspected 24 DNACPR forms throughout the ward areas. Some forms were appropriately completed. However, we did find eight forms had not been completed in line with national guidance published by the General Medical Council. The areas of shortfall included the counter signature of a consultant within 48 hours of the form being signed by a registrar or junior doctor. We highlighted 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 for all staff. Staff from the palliative care team and end of life care team had undertaken safeguarding training level two. The lead nurse for the service had undertaken safeguarding training level two. They were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.
- Ward staff were aware of the whistleblowing policy and felt they could report any concern. They were confident that concerns would be addressed. Staff from the palliative care and end of life care teams felt confident to report any concerns.

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Mandatory training

- The hospital palliative care team and the end of life care facilitators had completed mandatory training. This included training on fire safety, basic life support, moving and handling, and safeguarding adults and children. This was confirmed by checking records held centrally.
- The trust followed national recommendations from the National Care of the Dying Audit – Hospitals 2013/14 for hospitals to have mandatory training in end of life care for doctors and nurses. Mandatory training was provided to all staff. Across the trust in February 2015, the training had been completed by 521 nurses, but the data provided by the trust did not identify how many doctors had completed it.

Assessing and responding to patient risk

- Across the trust, 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.
- Overall, patients at the end of their life were monitored appropriately. For example, notes about care given to them were updated. Patients received regular nursing care. However, we found exceptions on ward E3 (a surgical ward) and the acute medical unit where staff told us, because they were so busy with patients on these wards, they were unable to give the specific attention that an end of life care patient would need.
- Because of nursing staffing shortage on ward E3 (a surgical ward) and the acute medical unit, we found no comfort rounds were undertaken. Comfort rounds were conducted by ward staff who visited every patient and asked them if they would like something to drink, or if they would like to be repositioned or use the bathroom. By not undertaking these rounds, frail patients on those wards were put at risk of falls because they would try to do things for themselves. However, we did not observe such an incident during our inspection. We alerted the trust that in both wards no comfort rounds were being undertaken. The trust took the necessary actions and on our return on the unannounced visit, we saw both E3 and the acute medical unit had reinstated comfort rounds.
- Staff on the wards were not aware of how to escalate changes in a patient's condition to relevant teams. In such instances, there was no clear process for ward staff

to follow. They either contacted the palliative care team or the end of life care team. In one instance they contacted them both. This lack of clarity could result in an inappropriate intervention.

- The trust had identified this gap in June 2014 and undertook their own audit that showed that in 94% of the cases there was a clinical assessment undertaken in the patient's last 24 hours of life. This was a positive improvement. During our inspection, we checked the notes of seven patients and in four cases we found an assessment had been undertaken and in three cases (two on ward E3 and one in acute medical unit) no assessment had been undertaken.

Nursing staffing

- The hospital palliative care team included 3.6 whole time equivalent (WTE) palliative care clinical nurse specialists. The end of life care team included 3.4 WTE end of life care nurses. Both teams were fully staffed and both teams had an 0% sickness absence rate over a period of nine months.
- However, staff told us that nursing vacancies, particularly on the medicines for older people wards, were affecting nursing care. This was having an impact on the care of some patients who were receiving end of life care on these units.

Medical staffing

- There was a 1.0 WTE consultant in hospital palliative care medicine. The trust had 1,200 beds and therefore medical staffing was not in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations, and the National Council for Palliative Care, which states there should be a minimum of one consultant per 250 beds.

Major incident awareness and training

- Both the hospital palliative care staff and the end of life care staff were aware of the major incident plan and actions to take in the event of a major incident.
- Mortuary staff were familiar with their role in a major incident. They told us that they could access additional facilities in the event that the mortuary reached its capacity. This was in partnership with other undertakers locally. There was also space created within the mortuary for additional bodies to be stored safely. The staff in the mortuary had received major incident training and were aware of any actions to take.

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Are end of life care 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 rated effective as requires improvement.

Following the national withdrawal of the Liverpool Care Pathway in July 2014, the trust introduced national guidance on the principles of care for dying patients and was piloting a new end of life care pathway. We found some staff were not aware of these principles and there was a reluctance to make end of life care decisions.

The AMBER care bundle was an approach used in hospital when doctors were uncertain whether a patient may recover. Generally, it was initiated when patients had a few months to live. The care bundle was only being used on some wards.

The trust only partially participated in the National Care of the Dying Audit – Hospitals 2013/14 and was not able to compare its performance with other trusts. For the organisational key performance indicators the trust scored better or the same for five out of seven indicators. Local audits demonstrated some progress with clinical and organisational performance indicators.

Most patients received appropriate pain relief and had appropriate nutrition and hydration.

Both the hospital palliative care team and end of life care team were supported to develop their knowledge and competencies. The hospital had strong links with the local hospice. While the organisation was not part of the trust, it worked closely with the palliative care physician.

The end of life care support team provided a seven-day service during specific hours. The hospital had access to 24-hour palliative medicine consultant advice 365 days a year.

Evidence-based care and treatment

- The trust's new draft end of life strategy was based on national guidance such as the National Institute for

Health and Care Excellence quality standard 13 (August 2011), which defines clinical best practice in end of life care for adults, and the Department of Health's National End of Life Care Strategy, July 2008).

- Following the national withdrawal of the Liverpool Care Pathway in July 2014, the trust introduced national guidance on the principles of care for dying patients. These principles were communicated to wards.
- The trust was also piloting a new end of life care plan (called the Achieving Priorities of Care Document) on four wards (one care of elderly ward and three oncology wards). The document is used in the last days or hours of life. Based on the results of this pilot, the care plan was to be rolled out across the organisation by summer 2015. These care plans were tailored to meet the needs of end of life care patients.
- During our inspection we found staff had limited awareness of those principles. On wards where the trust was piloting a new end of life care plan, staff were aware of these principles. The trust had issued specific 'yellow posters' on how to care for the end of life patient on all other wards. Some wards had these posters visible and others did not. There was no specific guidance to wards where the new care plan was not being piloted and nursing and medical staff were reluctant to make end of life decisions. This reluctance was leading to a poor patient experience because patients who were at the end of life were receiving active treatment when there was no benefit to them.
- The trust had launched the AMBER care bundle on the medicine for older people wards. AMBER care bundle was an approach used in hospital when doctors were uncertain whether a patient may recover. Generally, it was initiated when patients had a few months to live. Staff were aware of the AMBER care bundle and the end of life care team was raising awareness of this on the wards. The results of this implementation were being monitored and the latest audit showed 194 patients were placed on this pathway from April 2014 to January 2015. However, on wards where it was not used, ward staff relied on trust guidance that had been circulated in August 2014 on the principles of end of life care.
- The trust did not participate in the National Care of the Dying Audit – Hospitals 2013/14 regarding the clinical key performance indicators. The trust's performance could therefore not be compared with other trusts.
- A recent audit (January 2015) highlighted that patients referred to the hospital specialist palliative care team

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had a significantly reduced chance of dying in hospital, when compared with the national average for hospital deaths. 33.9% of patients had died in the hospital compared to 50% nationally.

- The end of life care team routinely audited preferred place of care for all referrals. A monthly audit was undertaken (July to December 2014) and the results showed that on average 96% of patients referred to the team died in their preferred place of care. This also formed part of the monthly quality monitoring report to the CSC Management Board.

Pain relief

- Pain assessment tools were used to assess patients' level of pain. Nurses were clear how to assess for changes to a patient's condition and what medication would be required. Patients were prescribed appropriate medication for symptom and pain management.
- The trust audit (June 2014) that showed in 60% of the cases there was documented evidence that 'use when required' medication had been prescribed. 'Use when required' medication ensured patients received medication they needed to control their pain or other symptom such as nausea or vomiting. This was a positive improvement; the national results were overall the same.
- Ward staff told us they had appropriate medications on the ward to use for pain. They told us anticipatory prescribing was managed well. The trust had audited the use of anticipatory prescribing, which showed that in 70% of the cases there was documented evidence that anticipatory medicines had been prescribed. Pharmacists also visited the wards regularly to ensure appropriate prescribing was taking place.
- The patient records we inspected showed most patients received appropriate pain relief. Patient records provided instructions for staff on action to take to meet patients' individual needs. We reviewed 20 records, and found one end of life care patient on E3 ward did not have pain relief medication recorded in their notes.
- Patients told us their pain and comfort was well managed. Relatives also shared positive comments regarding pain relief for patients.

Nutrition and hydration

- The trust undertook an audit (October 2014) that demonstrated 60% of patients had received a nutritional assessment. The national average was around 59%.
- The hospital used a screening tool, the Malnutrition Universal Screening Tool, to identify those patients who were nutritionally at risk. When patients were identified as at risk, there were fluid and food charts in place. There were at least five patients on the wards we visited who had no fluid or food chart in place.
- All staff were aware of the General Medical Council guidance on nutrition and hydration. Link nurses confirmed that care plans identified what patients could eat and these were regularly updated.
- Ward staff explained to us how they addressed people's religious and cultural dietary needs. The ward hostess explained the menus, including the provision of halal and vegetarian food among other options. Patients and relatives told us about the availability of various snacks and meals.

Patient outcomes

- The trust partially participated in the National Care of the Dying Audit – Hospitals 2013/14 for the organisational key performance indicators. The trust scored better or the same for five out of seven. It achieved the following key performance indicators: access to information relating to death and dying, continuing education, training and audit, prescription for medication for the five key symptoms at the end of life, and formal feedback processes regarding bereaved relatives' and friends' views of care delivery. The trust did not achieve access to support/care in the last hours or days of life and board representation for planning end of life care. The trust had an action plan and had appointed trust board representation and planning for care of the dying. It had also set up a protocol promoting patient privacy, dignity and respect. Any breaches to this were part of the monthly performance dashboard.
- The trust did not participate in the National Care of the Dying Audit – Hospitals 2013/14, 10 key performance indicators for clinical performance. Following the National Care of the Dying Audit – Hospitals, the trust undertook its own audits on the key performance indicators for clinical performance in June 2014. This

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included an audit of the patient's nutritional requirements, a review of patient's hydration requirements and a multidisciplinary recognition that the patient was dying.

- The trust action plan was updated in February 2015 and cross-referencing the national audit and the local audits was undertaken. This highlighted that the trust had made considerable progress in all of the clinical performance and organisational key performance indicators. However, the data were collected at different times and therefore the trust could not directly compare its performance with other trusts.
- Three wards (F5, F6 and F7) have received Gold Standard Accreditation. This is an internal accreditation of excellence that demonstrates quality care for people nearing the end of life. The wards had a certificate of recognition displayed.

Competent staff

- Both the hospital palliative care team and end of life care team were supported to develop their knowledge and competencies, including continuing professional development days, team meetings and further qualifications.
- The hospital palliative care team and the end of life care team had received clinical supervision and an annual appraisal.
- Most 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. However, we found on four different wards (E3, G2, G4 and F4) that staff did not have a full understanding of safety checks they needed to undertake when a patient was on a syringe driver. This could put patients at risk of not receiving the medication they required at the correct rate and quantities.
- Ward staff told us they required better understanding and training to support end of life care on the wards. While the presence of the end of life care team on the wards supported training and development of staff, not all wards where end of life care patients were cared for had received the necessary training in end of life care. The end of life care team recognised this and had plans to provide more training programmes.
- Most wards had a ward-based link nurse for end of life care, who was supported in developing their skills and knowledge in palliative and end of life care. We spoke

with two link nurses who told us their role was welcomed on the ward and valued by other staff. On E3 ward and the acute medical unit, there were no end of life care link nurses.

Multidisciplinary working

- The hospital had strong links with the local hospice. While the organisation was not part of the trust, it worked closely with the palliative care physician.
- The hospital palliative care team multidisciplinary meeting was held once a week. This team reviewed all cases of palliative care, including the appropriateness of medicines and achievement of preferred place of care. Patients who were discharged or had died were also discussed, including ongoing support to their families, where appropriate. The end of life care team did not attend this multidisciplinary meeting.
- The hospital palliative care team visited wards and provided teaching sessions to doctors on ward rounds.

Seven-day service

- The end of life care support team worked a two-shift pattern: 8.00am to 4.00pm and 3.00pm to 11.00pm, providing continuous cover from 8.00am to 11.00pm. The advice and review service was provided seven days a week, including weekends and bank holidays. It comprised a senior medical doctor and senior nurse.
- The hospital palliative care team was available 8.30am to 5.30pm Monday to Friday. Outside these hours, the wards had access to an on-call consultant. The on-call palliative care consultant provided out of hours telephone support and, where needed, weekend visits. The hospital had access to 24-hour palliative medicine consultant advice 365 days a year, through the strong links with the local hospice.
- Staff confirmed they could access advice and support from the team at any time.
- Chaplaincy support was available 24 hours a day, in person during office hours and by telephone initially out of hours.
- Mortuary support was accessible from 8.30am to 5.30pm Monday to Friday. Outside these hours, staff were available on an on-call basis.

Access to information

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- Staff had access to end of life information and guidance on the intranet. Staff found this resource valuable and easy to access. However, on two wards (E3 and acute medical unit) they were not able to locate the information on syringe drivers from the intranet.

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 24 DNACPR forms during our inspection. Five forms stated that the patient lacked capacity to make the decision around DNACPR, but there was no evidence that a mental capacity assessment had been undertaken.

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.

During our inspection we observed staff were compassionate and caring and treated patients with dignity and respect. Patients' care needs were met, although this was not consistent on wards E3 and the acute medical unit. Most staff we spoke with were very clear about their role in ensuring people received appropriate support. Families told us they were well informed about the condition of their relatives. They found the nurses and doctors shared information with them in a timely manner. Ward staff and relatives spoke highly of the support provided by the chaplaincy department to patients and relatives who were experiencing difficulties in coming to terms with death and dying. Recently, a Muslim family required additional support and the chaplaincy department requested help from a volunteer Muslim chaplain who was also an Imam of a local mosque to help support the patient and their family.

Compassionate care

- We spoke with six patients who were receiving palliative care and they were highly complimentary about staff. For example, one patient told us, "I have been very well looked after and the staff have been very kind and helpful. I could not ask for anything more."
- During our inspection we observed staff were compassionate and caring and treated patients with dignity and respect. Most staff we spoke with were very clear about their role in ensuring people received appropriate support. However, because of insufficient numbers of staff on E3 (a surgical ward) and the acute medical unit, we identified they could not always respond to end of life care patients adequately. We observed two separate incidents where patient needs were not met and families were having to provide support. This was highlighted to the trust during our inspection as areas of concern.
- Staff told us they undertook comfort rounds regularly. Comfort rounds are conducted by ward staff who visit every patient and ask them if they would like something to drink, or if they would like to be repositioned or use the bathroom. We checked two sets of patient notes that confirmed this. Relatives we spoke with confirmed the regular checks undertaken by staff. However, we had concerns on E3 and the acute medical unit where we found no records of comfort rounds undertaken for patients receiving end of life care. During our inspection, we highlighted these two areas of concern to the trust.

Understanding and involvement of patients and those close to them

- Families and friends told us they were well informed about the condition of their loved ones. They found the nurses and doctors shared with them information in a timely manner. One family member told us: "I was not overwhelmed with information. They told me as and when they knew I was ready to take more."
- The trust did not participate in the National Care of the Dying Audit – Hospitals 2013/14 clinical key performance indicators. However, they undertook their own audit of records (August 2014) and the results showed that 74% of records reviewed provided evidence that discussions with patients and relatives had taken place. This will be re-audited in April 2015.
- Patients and relatives told us both doctors and nurses were good at communicating with them about the care patients were receiving. They did not feel rushed and their questions were answered in a detailed manner. For

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example, one member of the family told us: “We are a large family and the nurses were patient as they explained to us what would happen to our father over the coming days and weeks. They discussed death and dying in a comforting way.”

- Relatives told us they were encouraged to get involved in the care of patients. For example, they were encouraged to provide mouth care for end of life patients. Mouth care kits were available on wards and were placed at the bedside. However, on E3 ward we found a patient’s relative was not given any support to provide mouth care to the patient. We raised it with a member of staff who intervened to help.

Emotional support

- Ward staff and relatives spoke highly of the support provided by the chaplaincy department to patients and relatives who were experiencing difficulties in coming to terms with death and dying.
- Chaplains and chaplain assistants 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 who they could call on to ensure patients’ religious wishes were met. Recently, a Muslim family required additional support and the chaplaincy department requested help from a volunteer Muslim chaplain who was also an Imam of a local mosque to help support the patient and their family.
- There was a special viewing room in the mortuary where relatives could spend time with the deceased patient. This room had a separate entrance from the side that enabled relatives to go directly to the viewing room. Mortuary staff were also available to support relatives.
- There was a small multi-faith room next to the chapel that was used by Muslim patients and relatives for prayers. There were signs in this room about daily afternoon and evening congregational prayers and Friday prayers. Items for prayers were also made available. We spoke with two relatives and three patients who told us they found the availability of this place of worship helpful to meeting their needs.
- Bereavement support staff provided support to relatives and friends after the death of a patient. This included bereavement care meetings where relatives were provided with information on post mortem, registration of death procedures, funeral arrangements and others. We found the service was stretched with not enough

staff to support relatives. Until 2013, the service had five members of staff and a recent report by a lay governor of the Fareham and Gosport clinical commissioning group had highlighted that the recent cuts to numbers of staff working in the department (from five to two) had affected the quality of service provided to the relatives. The report was submitted in September 2014 and discussed with the trust who will factor service provision into the business planning process for 2015/2016.

Are end of life care services responsive?

Good



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

We rated responsive as good.

Services were being planned and delivered to meet the needs of the local population. For example, the trust had introduced a seven-day service on the ward by the end of life care team and was planning to merge the palliative care and end of life care teams to provide a more seamless service. Information was being used to improve awareness of the service across the trust so that patients were appropriately referred to the teams.

Most patients were being seen within 24 hours of referral to the teams. Many patient requiring end of life care were treated in side rooms. There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than national average.

Patients and their relatives were being informed of the decisions taken around end of life care. There were good multi-faith arrangements to support patients. Translation and interpreter services were available but all information leaflets were in English and there were none in easy-to-read formats. Portering and the mortuary had good arrangements to preserve the dignity of patients who had died.

There were special arrangements to support relatives, for example with refreshments and parking. The learning from complaints was shared to improve the service.

Service planning and delivering to meet the needs of local people

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- The hospital palliative care team and the end of life care team collected and analysed detailed information about patients to provide a service that met people's needs. This included information such as the number of referrals, referrals seen within 24 hours, where they were seen and reviews undertaken. This information had been used to support a seven-day end of life care team service.
- The trust had plans for the hospital palliative care team and the end of life care team to be merged to ensure end of life care patients received appropriate care. The teams currently worked under the surgery and cancer service and the medical and older people's rehabilitation service and this had caused uncertainty with planning and organisation and for staff referrals across the trust. The merger was planned for 1 March 2015 to ensure a more seamless service.

Access and flow

- Wards were not clear whether to refer patients to the end of life care team or the palliative care team. Referrals were made by telephone contact. During the inspection we found one patient was referred to both the end of life and palliative care teams. However, if a patient was inappropriately referred to the palliative care team, they referred them onto the end of life care team promptly.
- Ward staff told us there were no delays for patients to be seen. The palliative care team monitored the time it took for the team to visit the ward. In a recent audit (June 2014), 76% of referrals were either seen on the day of the referral or the day after that. As a result of this audit, the team introduced a new system to ensure patients were seen in a timely manner. For those patients who might be delayed being seen, the team introduced telephone contact with the ward during the multidisciplinary team meeting to get further details on the patient. A re-audit was planned for April 2015 to assess whether the results have improved.
- The trust had only recently (July 2014) started recording the numbers of referrals because the previous system could not provide reliable data. In July 2014, the palliative care team had 105 referrals and the clinical time spent was 232 hours. Proportionally, the least number of referrals to the specialist palliative care team

came from Medicine for older people. This was thought to reflect the input by the end of life nursing support team on these wards. The palliative consultant had planned a training session with the surgical team.

- The end of life care team also monitored referrals and since July 2014, when the team started collecting the data, it has received on average 70 referrals a month. The number of these referrals was increasing, suggesting there was greater awareness among ward staff of the end of life care team's role and the benefit their intervention could have on patients.
- Staff on the wards felt that both the hospital palliative care team and the end of life care team were helpful and approachable. The trust did not participate in the National Care of the Dying Audit – Hospitals 2013/14 clinical key performance indicator. However, the palliative care team undertook their own audit and found that 83% patients had access to specialist care in the last hours of life.
- Data for the months of April, May and June 2014 were reviewed and it was found that 48% of the patients were seen by the hospital palliative care team on the day of the referral and 28% within 24 hours of referral, with only 3% waiting for more than 48 hours for a review.
- The trust had a rapid discharge service for discharge to a preferred place of care within 24 hours. There were plans to audit this in April 2015. However, the end of life care team told us that discharge took place within hours of them being informed. The national average for patients with cancer dying at home is 17%. A recent trust audit (2014) had shown that this percentage rose to 50% for patients known to the specialist palliative care team. The service was reviewed regularly with commissioners. Recently (September 2014) there had been concerns regarding delays in relatives receiving death certificates. The commissioners reviewed the process and found that the reason for the delays was the number of deaths in hospital that had been referred to the coroner.
- A snapshot audit of place of death (April to December 2014) demonstrated that the trust hospital palliative care team had fewer patients referred to them who died in hospital when compared with the national average (33.9% compared to 50%). The end of life support team had also reviewed preferred place of death (July to December 2014), and this was met for 95% of patients referred to the team.

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- The trust had close links with a local hospice two miles from the trust. Admission to the hospice was requested on the basis of clinical need for individual needs of patients and the admission criteria of the independent hospice. Close links were also maintained with other specialist palliative care services in the area, and referral was made to these services on a similar basis.

Meeting people's individual needs

- End of life care patients were mostly cared for in a side room. Relatives were supported with refreshments and special parking permits that allowed them to use car park facilities at minimum cost. These permits were available for all members of the family.
- The trust carried out regular audits of do not attempt cardiopulmonary resuscitation (DNACPR) forms. The last audit was in October 2014. The audit looked at 40 forms. In all forms the reasons for do not resuscitate were clearly documented; 70% were documented as having been discussed with the patient. It is possible that in some cases these discussions were not able to be held with the patient because of the patient's reduced conscious level or appropriateness of holding a conversation with the patient at that specific time. Since the previous audit, there had been a significant improvement. For example, there had been an increase in the number of decisions being discussed with patients from 58% to 70%.
- We looked at 24 DNACPR forms and care plans. We found that doctors had a conversation with patients or their relatives and this was documented on the form and in the patient records.
- Patients and relatives told us how staff respected the families' cultural and religious requests and encouraged them to share their wishes with staff. For example, some relatives requested to spend additional time with the deceased as a family. The numbers could not fit into the room and so arrangements were made to hold the viewing in the multi-faith room.
- The trust had a transplant coordinator who gave information around post-mortem and organ transplantation. We saw that the information booklets were available for patients and families to read and make appropriate and timely decisions.
- There were various printed information leaflets available to patients and their relatives, including leaflets on what support to give patients and their 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. 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.
- Because the trust did not participate in the clinical key performance indicators, there was no information on how the trust compared with other trusts on certain other indicators. However, the trust undertook its own audit of spiritual needs assessment at the hospital and found that it was undertaken for 65% of patients. This was higher than the England average of 37% as demonstrated in the National Care of the Dying Audit – Hospitals 2013/14. The high profile of the chaplains and chaplain assistants was noticeable on the wards. The chaplaincy multi-faith team regularly organised training for staff on wards on how to meet the needs of the various faith communities. The chaplaincy team also involved leaders of the other faiths in the community and invited them to volunteer as chaplain assistants.
- Porters told us that the body of the deceased would be transported to the mortuary on the bed on which they passed away. However, this would be covered with a collapsible plastic cover making the bed look like a large table. This was a very respectful manner in which to transport a body.
- Mortuary viewing facilities were appropriate and allowed relatives privacy. It was accessible from the outside, avoiding family members having to pass through the mortuary to view the deceased. The room was appropriately furnished and staff were available to answer questions and signpost relatives to appropriate people if they had any questions or queries.
- On the oncology wards, a dedicated room was made available to the relatives of patients at the end of life that had books, games, a TV and DVDs available, as well as sleeping facilities. There were also fold-away mattresses that could be placed in the patient's room for overnight stays, which the staff encouraged.
- Relatives were supported with refreshments and special parking permits that allowed them to use car park facilities at minimal cost. Relatives told us that they were able to visit the ward at any time when their relatives were approaching the end of life.

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Learning from complaints and concerns

- The trust's patient advice and liaison service helped patients and relatives to raise concerns about the care being given during the hospital stay. Patients and relatives we spoke with knew how to raise any concerns and make complaints if they needed to. Information for patients on how to raise concerns and complaints was available throughout the hospital.
- The hospital palliative care team had received no complaints from relatives regarding end of life care. However, the trust had received four complaints between February 2014 and February 2015 related to end of life care. The trust investigated these complaints and found three of these complaints were not upheld and one was upheld. The learning from these complaints was shared with staff and the trust board. It was shared through staff meetings. The learning included the importance of sharing up-to-date information with relatives.

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 leadership team had developed a draft revised strategy for end of life care that took into account national guidance and reports on improving end of life care. The strategy outlined initiatives to improve and monitor the quality of care, care coordination and the culture of care in the trust and working with community teams. It defined how end of life care could be structured with roles and responsibilities for the end of life care team and the hospital palliative care team. The vision set out was about developing a seamless service for patients, carers and relatives in an integrated way. As part of this vision the palliative care team and end of life care team were to merge. This revised draft strategy was out for consultation. The trust end of life steering group had identified an audit programme to monitor the quality of the service and there was a performance

dashboard that was presented to the trust board on a monthly basis. The trust had made a mistake in not fully participating in the National Care of the Dying Audit – Hospitals, but had taken steps to rectify this and monitor standards.

The leadership was knowledgeable about quality issues and priorities. Senior staff members took appropriate action to address these issues. There was a culture of responsibility between the end of life care team and the palliative care team. However, risks needed to be better identified, assessed and managed.

The trust had a 'listening into action' initiative that enabled staff to provide solutions to common challenges for end of life care in the trust. Patients and their relatives were to be consulted on the strategy and the relatives of bereaved patients had been surveyed to improve the service. There were innovations in practice, which included integrated care and trained volunteers to support patients.

Vision and strategy for this service

- The trust's vision and values were displayed throughout the hospital, on the intranet and formed the basis of the staff development review and appraisal process. Staff we spoke with were aware of and committed to deliver the trust's visions, values and objectives. For example, all staff we spoke with recalled the trust motto of 'working together for patients with passion and pride'.
- The end of life care vision was to provide quality of care, ensure coordination of care and promote a culture of care. The trust palliative care team and the end of life care team were starting to work jointly with the aim of providing high-quality end of life care and palliative care across the trust. For example, they started to have joint meetings. The teams were managed in separate clinical structures, though there were plans to merge, working in one clinical service centre to provide a clearer, more seamless service.
- The trust strategy for end of life care was in draft form and had to be re-written after the national withdrawal of the Liverpool Care Pathway. The revised draft strategy took account of the national guidance from the Department of Health and the National Institute for Health and Care Excellence and the more recent Francis Report on the Mid Staffordshire NHS Foundation Trust Public Enquiry (2013), the National Survey of Bereaved People (VOICES) 2013, 'One Chance to Get it Right' by the Leadership Alliance for the Care of Dying People

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(2014). The draft strategy outlined initiatives to improve and monitor the quality of care, care coordination and the culture of care in the trust and working with community teams. It defines how end of life care could be structured with roles and responsibilities for the end of life care team and the hospital palliative care team. The draft strategy had been sent out for consultation and was to be ratified by the end of life steering group in January 2015, although this had not been completed at the time of inspection.

- The hospital palliative care team and the end of life care team understood the priorities for end of life care services. One of these priorities was to ensure coordination of care across the trust. This objective was widely shared across the organisation. For example, to enhance the coordination of end of life care in general surgery, the palliative care team organised with the surgeons a teaching and learning session for junior doctors in end of life.

Governance, risk management and quality measurement

- The trust end of life steering group had been in existence since 2012 and coordinated the service across the trust. The steering group met every six weeks. The purpose of this group was to support the trust to embed end of life care. It had identified objectives for high-quality end of life care and was working towards delivering those objectives. A work plan was set out by the steering group and monitored at the board level. The board also monitored the quality of the service. The end of life steering group chair had been invited by the board to discuss the quality of care provided to patients dying in the hospital.
- The end of life steering group had identified an audit programme to monitor the quality of the service. The trust did not take part in the clinical key performance indicators of the National Care of the Dying Audit – Hospitals 2013/14 because of lack of administrative support. A local audit was subsequently undertaken using the national standards, although the data (because of time periods) was not comparable nationally. The new director of nursing who had recently (January 2015) taken on the responsibility for end of life care at the board level, recognised the gaps in the monitoring systems and had plans to address these.
- The hospital palliative care team had regular team meetings where the team discussed patient care, how

well the department performed meeting various targets, and the quality of the service. These meetings were held once a week and were well attended by the team. The end of life care team was not part of these meetings but would be once the teams merged. The plan to have the two teams merged had been ongoing for over two years. Only recently (December 2014) had this plan been formally signed off.

- The hospital palliative care team had undertaken an activity survey (July 2014) and previous audits of records in 2013. We did not see examples of other monitoring.
- The end of life care team had developed their own performance dashboard. This was presented to the CSC Management Board on a monthly basis. The performance dashboard included information on audits undertaken, the results of the do not attempt cardiopulmonary resuscitation audits and the availability of side rooms for patients at the end of their lives. The CSC Management Board also received a report on the progress in ensuring the objectives set out in the work plan were met.
- There were no issues on the trust risk register specifically pertaining to end of life care. For example, issues with care plans and nurse training on syringe drivers had not been identified.

Leadership of this service

- The new director of nursing who started in January 2015 was the board lead with responsibility for end of life care services in the trust. The previous acting director of nursing was the board lead with responsibility for end of life care services in the trust until December 2014 and attended the meetings regularly and championed the work of the end of life care team at board level.
- The service was led by the consultant in palliative care, who also chaired the end of life steering group. He also provided medical leadership to the end of life care team. Doctors and nurses on wards told us the consultant was very visible and knowledgeable regarding palliative care in the organisation.
- The hospital palliative care team were managed by the surgery and cancer clinical service centre and the end of life care team were managed by the medical and older people rehabilitation services. There was some uncertainty in the trust as to roles and responsibility of each team. There was, however, ongoing discussion as to how the teams could work together and eventually merge.

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Culture within this service

- All clinical nurse specialists and end of life care staff we spoke with, including those working in the bereavement office and in the mortuary, told us that they believed they delivered good care to patients at the end of life and after death. A recent survey of relatives whose loved ones died in hospital highlighted high level of satisfaction with the service. This complemented the number of comments and cards received by wards from relatives regarding the care provided to dying patients.
- The hospital palliative care team and the end of life care team were both passionate and dedicated to providing high-quality end of life care. For example, the bespoke key performance indicators created by the department enabled them to monitor the quality of the service in a very meaningful way.
- Staff reported positive working relationships and we observed staff were respectful towards each other, not only in their specialties but across all disciplines.
- Staff across the trust were proud of the work they did and we saw the commitment they had. Staff told us the 'listening into action' initiative had improved staff morale and had an impact on staff attitude.

Public and staff engagement

- The trust had a 'listening into action' initiative that enabled staff to provide solutions to common problems. Staff we spoke with welcomed this initiative. They told us that it enabled them to be involved in the day-to-day workings of the organisation and provide solutions to situations they faced. For example, a staff member told us how they were concerned about the location of the waiting area for end of life care patients waiting for patient transport. The location was such that when it rained, though there was a shelter outside, patients got wet. They raised this with their line manager and







together they came up with potential solutions for the problem and the solution of placing the shelter inside the building. The result was a solution was implemented in three weeks that improved the patient experience.

- The trust undertook a survey of bereaved relatives and as a result of it implemented seven-day working for the chaplaincy department.
- There were plans to consult relatives and friends on the end of life care strategy.

Innovation, improvement and sustainability

- The trust had introduced a volunteering programme for people who wanted to work as chaplain assistants. Volunteers were trained on how to support patients by visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust has participated in the development of a palliative care handbook for use across the Wessex region. This book contained guidelines on clinical management of palliative care. Doctors we spoke with found this handbook invaluable as a resource for treating patients effectively.
- There were strong links between the commissioners and the end of life steering group that recognised the work of the team and other departments such as the mortuary, the chaplaincy department and bereavement services that supported relatives after the death of their family member.
- In partnership with the local hospice, one of the trust oncology consultants within acute oncology, had created an innovative referral pathway to facilitate timely transfer for patients identified by the consultant, as requiring hospice care as soon as possible after admission to the trust.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at Portsmouth Hospitals NHS Trust provides outpatient appointments and diagnostic services for a wide range of specialities, including medical, surgical and ophthalmic disciplines. The trust operates outpatient clinics from Queen Alexandra Hospital, with peripheral outpatient clinics held at St Mary's Hospital, Gosport War Memorial Hospital and Petersfield Community Hospital. The trust also provides renal dialysis services at Portsmouth, Basingstoke, Havant, the Isle of Wight, Chandlers Ford, Salisbury, Milford, Bognor Regis and Totton. The adult's outpatient department provided 227,799 new appointments and 309,573 follow-up appointments in 2013/14.

Diagnostic imaging services are provided mainly at Queen Alexandra Hospital, with some plain film x-ray provision at Fareham Community Hospital, Gosport War Memorial Hospital and Petersfield Hospital. They offer patients magnetic resonance imaging (MRI), computerised tomography (CT) scanning, ultrasound, x-rays, nuclear medicine, interventional radiology and breast imaging. The imaging departments operate an extended working day to accommodate patients in the evenings up until 8pm for outpatients. There are other diagnostic services provided by the trust. These include echocardiography and phlebotomy.

Outpatient appointments are available Monday to Friday between 8.30am and 5pm. Patients can make appointments with the centralised appointments service between 8.30am and 5pm Monday to Friday.

During two separate visits we inspected ophthalmology, rheumatology, ENT, maxillofacial, oncology, general surgical and medical, including the respiratory centre, renal and cardiology clinics. We also inspected the dialysis units at the Isle of Wight and Queen Alexandra Hospital. In total, we spoke with 60 patients and 72 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 attended focus groups and listening events. We observed care being provided.

Outpatients and diagnostic imaging

Summary of findings

All outpatient and diagnostic imaging departments demonstrated good knowledge of reporting incidents and of learning from incidents. These were often shared with other outpatient specialities, but real learning only occurred within the speciality reporting the incident. All mandatory training, including safeguarding and infection control, was completed by all staff. Compliance for mandatory training was well monitored by senior staff members.

National Institute for Health and Care Excellence guidelines were followed in many departments and some excellent examples of practice was demonstrated. Staff were encouraged to develop professionally and regularly update their clinical skills. Rheumatology, dialysis and respiratory outpatient departments demonstrated outstanding practice and accomplishments.

Patients were positive about their experiences of care, including care that had been extended to relatives.

In ENT, patients were given access to a private room when they were being given difficult news or were distressed. A symbol on the door indicated to other staff not to enter the room. The privacy and dignity of patients was mostly adhered to. There were, however, some concerns about the building design affecting the privacy of patients in the dialysis unit on the Isle of Wight and in the ophthalmology department at Queen Alexandra Hospital. There were risks relating to infection control at the dialysis unit on the Isle of Wight.

Staff across outpatients and diagnostic imaging demonstrated a good understanding of how to make reasonable adjustments for patients living with dementia or those with a learning disability.

The waiting times for diagnostic imaging have historically been significantly higher than the national average up until July 2014. The Trust had met the waiting times for diagnostic imaging from September 2014, having extended the working day in the service to achieve this. In rheumatology, a rapid access clinic operated. Patients may receive an appointment that suits their existing commitments; often same-day

appointments are available. It also provided innovative patient education and support conferences that are well attended by patients and have been nominated for awards.

The referral-to-treatment targets for most outpatient specialities were being met, although colorectal, back pain and the gastroenterology clinics had longer waits. The trust taking action to addressing this issue. Cancer urgent referral times for patients to be seen within two weeks were being met.

Ophthalmology had a high number of patients awaiting follow-up who were significantly delayed in receiving their follow-up appointment and were on the outpatients waiting list. This had been on the service risk register since 2009, as a result of a serious incident requiring investigation that occurred as a result of this backlog, it was escalated to the trust risk register In April 2013. This number had been reduced, but the number of patients waiting was still significant. The learning from this had improved how risks were escalated. Risks were being managed and waiting lists and service quality was monitored.

Renal outpatient letters were taking 35 days to be typed and sent to the patients' GP. This was because the renal department had a separate IT system from the rest of the trust. It had caused significant delay in GPs receiving updated information regarding their patients' treatment. An outpatients administration review was underway to improve services within the department.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



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

We rated safe as good.

Throughout the trust all outpatient and diagnostic staff were clear about incident reporting procedures. They felt confident with the process for initially reporting online and most staff confirmed that they received feedback about the incident from their line management. It was evident that learning was shared following incidents, but generally kept within the speciality they related to. There was clear evidence of change in practice as a result of incidents occurring. For example, in ophthalmology, an incident occurred where the wrong size lens was implanted into a patient's eye. The matter was corrected swiftly and practice changed to prevent this occurring in the future.

All mandatory training was up-to-date and staff held copies of the essential skills handbook to ensure that they had covered all safeguarding training and other mandatory learning, such as infection control and manual handling. Records were kept by line managers to ensure all staff received their mandatory training.

Resuscitation trolleys were checked daily and staff followed correct procedures to ensure that all equipment was in date. Medicines were secured correctly and patient group directions were all in date where used.

The dialysis unit on the Isle of Wight presented an infection control risk because the isolation room did not accommodate a bed as well as the equipment required for dialysis so patients requiring isolation were accommodated in the ward area with a curtain surrounding.

Across outpatients and diagnostics there were some vacancies for nursing staff and radiographers, although staff did not feel that this impacted on their workloads or department cover. Recruitment was being carried out for these positions, but it was difficult to recruit nursing staff in some specialist areas, such as renal dialysis. Staff were often asked to work in other areas, sometimes leaving their

own units short. The staff left behind felt that they had to compensate for the member of staff taken to work elsewhere but identified that appropriate care was delivered.

Incidents

- In outpatient clinics there was clear evidence of feedback from incidents being disseminated among all staff and learning shared to improve patient outcomes. Feedback was kept within each speciality, although a newsletter 'SIRI-ous business' was emailed to staff to update on trust-wide incidents. Not all staff knew about this newsletter.
- There was one serious incident requiring investigation reported in ophthalmology during 2013/14. This incident involved the wrong size lens being implanted into a patient's eye. After root cause analysis the trust discovered this was an administrative error. Learning was shared with all staff and administrative practices were altered to ensure this did not reoccur.
- In diagnostic imaging all staff told us that they felt confident in reporting incidents. They used an electronic reporting system and also completed a radiation incident form. Staff felt that the department had an 'open culture' about incident reporting and were encouraged by senior radiography staff to report incidents.
- Reportable incidents around ionising radiation medical exposure need to be reported to the Care Quality Commission under ionising radiation medical exposure regulations (IR(ME)R). The trust had reported four reportable incidents between March 2014 and February 2015 to the Care Quality Commission. The number of reports was within the expected range for diagnostic notifications and was similar to other trusts when compared with the level of activity.

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their

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families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS

- Most staff were aware of the duty of candour but it was not evident that formal training had been provided in relation to this.
- Staff could provide examples of how the duty of candour was adhered to in everyday practice. In radiology, a patient who had been given the wrong diagnostic scan was written to with an apology and invited to discuss matters further.

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic areas were visibly clean.
- There was good evidence of personal protective equipment, such as gloves and aprons, being available in each outpatient department and staff were observed using personal protective equipment where necessary.
- Hand washing facilities were available in each clinical room.
- 100% of staff across outpatients and diagnostic imaging had completed mandatory infection control training, corroborated by online staff training files.
- Hand gel was available in all communal areas, and in clinical rooms.
- Ward noticeboards displayed infection control and hand hygiene audit outcomes, reflecting compliance across outpatient services of between 98% and 100%.
- During our inspection we observed waste bins being emptied and none were overflowing.

Environment and equipment

- The environment was clean and tidy.
- There was adequate room for patients to sit and wait for appointments in most areas. However, in the dialysis unit on the Isle of Wight the waiting area was small, with only nine seats for patients who were waiting for dialysis or outpatient clinic appointments. The location of the waiting area was not appropriate, with patients having to walk from the waiting room, through the dialysis unit where patients were receiving treatment, to the consulting room for their outpatient appointments.
- The isolation room within the dialysis unit on the Isle of Wight was not big enough to accommodate a bed as well as the equipment required for dialysis. Therefore, patients requiring isolation were accommodated in the

ward area with a curtain surrounding. This presented an infection control risk to other patients receiving dialysis within the unit. The lack of adequate isolation cubicles in the dialysis unit was on the trust risk register. No action was identified.

- In ophthalmology, the waiting area was small for the number of patients waiting to be seen in clinic, with many patients having to stand. Patients were also undertaking their visual acuity testing in a busy corridor where the passage of staff and other patients had to be stopped to allow vision tests to be completed with a patient. There was also no privacy afforded to patients being treated in the clinical area for pupil dilation. The room used was surrounded by glass and other patients could clearly see treatment being provided.
- The consulting rooms and waiting areas in all the hospital's outpatient locations were wheelchair accessible.
- The portable appliance testing on all the 25 items of equipment we looked at was in date and the equipment appeared in good condition.
- Daily checks of the resuscitation trolleys were completed in all areas, and all the equipment was in date.

Medicines

- All medicine cupboards were locked appropriately and drug fridges were checked and in order. Fridge temperatures were checked daily and were in line with national guidance.
- Prescription pads were stored securely.
- All patient group directions were in date.

Records

- All records that were observed during inspection were of a good standard. Online records were easy to locate and well maintained. Paper records were clearly written, dated and kept in good order.
- Not all patient information was kept securely and away from public areas. In some clinics, patient notes were kept outside the consultant's room opposite where patients were waiting for their appointments and so were easily accessible to patients in this area.
- The trust data demonstrated that 99.98% of records were available for outpatient clinics in January 2015.

Safeguarding

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- All staff we spoke with from outpatients and diagnostic imaging had completed their mandatory level two safeguarding training. When children were seen in the department, for example in rheumatology, there was a member of clinical staff available who had completed their level three safeguarding.
- All staff knew how to report a safeguarding concern and who to speak to within the trust for further advice if required.

Mandatory training

- All mandatory training was up to date, including infection control, safeguarding and manual handling. This was evidenced by online reports and paper documentation in staff files.

Assessing and responding to patient risk

- All staff were clear of the procedure to follow if a patient deteriorated while visiting outpatient clinics or diagnostic imaging departments.
- In diagnostic imaging, there was clear evidence of robust risk assessment tools for patients having MRI and CT scans that were widely used. There were also clear policies in place to respond to patient risk, for example, for patients who develop claustrophobia while in the MRI scanner.
- There were adequate numbers of resuscitation trolleys available in each clinical area. Each department was responsible for the maintenance of their own resuscitation trolley.

Nursing staffing

- Most outpatient clinics had at least one vacancy for a staff nurse, senior nurse or healthcare support worker. Recruitment had begun to fill most of these positions. Some clinical specialties were finding it difficult to recruit nursing staff with the specialist skills required. In particular the renal dialysis units found it more difficult, but they were keen to provide training and support to nurses who met most of the recruitment criteria.
- In diagnostic imaging there were staffing shortages. There was a vacancy rate of 17.68% of professional and technical staff in imaging in Queen Alexandra Hospital and 17.69% at Gosport War Memorial Hospital. Student radiographers from the University of Portsmouth currently working within the unit had been approached to fill these positions.

- Staff told us that they had to work in other areas if departments were short staffed, even if they did not feel they had the appropriate skills to be effective. In the renal unit, staff were asked to work in other areas that were struggling with low staffing levels, but staff were not replaced on the renal unit. This was a specialist area and the remaining staff then had to cover the missing member of staff. Staff told us that patients still received the appropriate level of care.

Medical staffing

- In ophthalmology, consultants start clinics between 9 and 9.15am; patients are given appointment times which commence at 8.15am to allow non-medical assessments to take place. However, this led to the clinic then running late all morning, with long delays for some patients. Patients told us that the delay following these tests was their main area of complaint during their pathway through the ophthalmology department.
- Senior nursing staff felt that there were adequate numbers of consultants and registrars to meet the needs of outpatient clinics.
- The vacancy rate for medical staff in imaging was 18.37%. Radiographers felt that there was always a radiologist available for clinical support, either in the hospital itself or on-call.

Major incident awareness and training

- Staff were aware of their roles and responsibilities during a major incident and knew who to contact if they required assistance or further information.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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.

Outpatients and diagnostic imaging

There was good evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in oncology and renal outpatient clinics and also in diagnostic imaging. Local guidelines were also incorporated into clinical practice and kept up to date. The trust had outstanding practice that was recognised nationally and internationally in its rheumatology service and home renal dialysis service.

Staff worked in multidisciplinary teams to coordinate patient care. There were good examples of this in cancer services and in the respiratory centre where staff also provided outreach services into the community.

Outpatients and diagnostics staff had good access to training and opportunities for professional development. Staff had annual appraisals and were encouraged within their own departments to enhance their specialist skills. There was a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, to ensure decisions were made in patients' best interests.

Seven-day outpatient services were not developed but were operating in diagnostic imaging, and this included access to CT and MRI scans.

Evidence-based care and treatment

- Outpatient services adhered to the relevant NICE guidelines to treat patients. For example, we reviewed the clinical guidance for oncology, renal services and diagnostic imaging and they all referred to NICE guidance.
- Research and specialist nurses kept outpatient staff up to date with all relevant local and national guidelines for each speciality.
- The rheumatology department received an award in 2013 from the British Society of Rheumatology (BSR) for outstanding best practice. It was also nominated for its rapid access clinic, day case unit and patient education conferences. The department was nominated for a patients' champion award by the National Rheumatoid Arthritis Society (a patients' group) and it won the National Osteoporosis Society chairman's award for patient education.
- The home dialysis service within the renal department is the largest of its type in the UK and sixth in the world. The dialysis research nurses won an external award in 2014. Senior nursing staff told us that there was ongoing training of patients from the Isle of Wight clearance

clinics on home dialysis, with the training being carried out at Havant so avoiding any spell of unit-based dialysis. This had been presented at both national and international meetings, the latter in Boston in 2014. They have also provided training for UK nurses to allow them to implement this service in their own units. Patients with appropriate access could be home within eight days of starting on haemodialysis. This practice and sharing would be considered exceptional.

Patient outcomes

- The trust's follow-up appointment to new appointment ratio was one of the lowest in the country.
- There were examples of participation in national audits. For example, in renal dialysis they were involved in the European Dialysis and Transplant Association audits. The rheumatology department participated in the National Clinical Audit for Rheumatology and Early Inflammatory Arthritis

Competent staff

- We were provided with documentation to confirm that all nursing and support staff had received an annual appraisal, all of which were up to date and comprehensive.
- Nursing staff, radiographers, healthcare assistants and administrators from each speciality were offered training opportunities to develop professionally and gain the latest skills and knowledge relevant to their post.
- All staff felt confident in their knowledge in looking after a patient living with dementia or a learning disability. They received training in relation to caring for patients living with dementia and in some outpatient teams there were trained 'dementia champions' who gave advice and support to other colleagues if required.
- Some nurses were aware of revalidation, which had yet to be introduced nationally for nursing staff but was being planned. The nursing staff were aware of their responsibilities. Most said that they hadn't received any formal updates from the trust, but took their own initiative to ensure that they met the requirements.

Multidisciplinary working

- In oncology outpatients, staff told us that the multidisciplinary team worked well. It was well

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supported by a number of specialities, including surgery and radiology. Multidisciplinary team meeting minutes were seen, which corroborated good attendance from all specialities.

- Most outpatient clinic staff felt that they had good working relationships with all their colleagues, including consultants, physiotherapists and radiographers. It was particularly apparent in rheumatology, renal/dialysis and the respiratory departments, where nursing staff reported excellent working relationships with the consultants.
- Radiographers told us that they had good working relationships with all their clinical colleagues and in particular the radiologists. They sought advice and support when required from the Radiology Access Unit.
- In the respiratory department specialist nurses would visit wards around the hospital to undertake teaching sessions with staff, developing links with nurses, physiotherapists and medical staff throughout the trust. The department also maintained strong links with the community respiratory nurses to improve outcomes for patients in the community.

Seven-day services

- Outpatient appointments were available Monday to Friday between 8.15/8.30am and 5pm.
- Diagnostic imaging had operated a seven-day service in MRI, CT scanning, ultrasound and plain films since January 2015. Plain films and ultrasound were available for inpatients 24 hours a day seven days a week. It also operated an extended working day until 8pm to offer outpatients the opportunity to attend outside working hours and to reduce the current waiting times to meet the six-week target. This has meant that staff have transferred from short day working to long day working. The effectiveness of maintaining the six week national target and the impact on staff was to be audited. This was not completed yet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Some staff had received training that had been cascaded to colleagues. They were able to give good examples of consent being sought and who to contact if they required further information. Staff had guidelines available to them in paper format and online.

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.

We observed staff being friendly, approachable and caring. Patients told us they were happy with the care they received and were treated by kind and caring staff within outpatients and diagnostic imaging. They told us that they felt included in decision-making and care planning in relation to their conditions.

In ENT special provision was made to ensure patients who were distressed were given a room to privately discuss matters with their clinicians.

Compassionate care

- During our inspection we observed care being provided by nursing, medical and other clinical staff. Throughout outpatients and diagnostic imaging, staff were friendly, approachable and professional. Patients and their relatives clearly felt at ease.
- Patients reported a positive experience. For example, one patient told us “The staff here are very caring and supportive. I’m not treated as a number. They are absolutely outstanding”.
- We observed staff speaking with an older patient who became very upset after spilling a drink. They were calm and helpful and the patient was immediately reassured.

Understanding and involvement of patients and those close to them

- Most patients felt well informed and included in the entire decision-making process in relation to their care and treatment from start to finish. For example, one patient told us “I have a good dialogue with the team that look after me, I have confidence in them”.
- When patients felt they did not understand what was being discussed, they felt able to question their clinicians to be confident that they were aware of the details of their treatment.

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- In oncology outpatients we observed a warm rapport between patients, relatives and nursing staff. Patients addressed nurses by their first names and chatted informally about their lives. This demonstrated a personal feel to patient care.

Emotional support

- Patients commented that they had been well supported emotionally by staff, particularly patients who had received bad news in relation to their illness and had been distressed as a result.
- There were dedicated rooms to take patients who were upset to discuss matters in a private setting. In the ENT department, when patients are being given difficult news, a teddy bear symbol is placed on the door of the room to alert staff not to enter the room at that time.
- A chaplain was available at the trust during the day between 8.30am and 4.30pm and on-call outside of those hours. The chaplain is able to contact other world faith leaders as required by patients.

Are outpatient and diagnostic imaging services responsive?

Good



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

We rated responsive as 'good'.

The trust was meeting referral-to-treatment time targets for most outpatient specialities but there were long waiting times for patients attending colorectal clinics, back pain clinics and the gastroenterology clinic. There was evidence of action being taken to address the long waits.

The trust 'did not attend' rate was significantly lower than the England average. The trust was now meeting waiting times for diagnostic imaging, having extending the working day in the service to achieve this. The cancer waiting time target for urgent referrals to be met within two weeks was being met.

In rheumatology there was a rapid access clinic and patients were given the opportunity for an appointment that suited their schedule.

Dignity and privacy were maintained in nearly all clinical settings. The respiratory clinic did not have a waiting list, and could provide separate clinics where patients were able to be seen within a same-sex environment. However, the dialysis unit on the Isle of Wight and the main ophthalmology department were not able to meet this requirement because of the design of the buildings and consultation rooms.

Staff across outpatients and diagnostic imaging demonstrated that they had a good understanding of how to make reasonable adjustments for patients living with dementia or those with a learning disability. Dementia champions were available in outpatient departments throughout the trust.

Ophthalmology had a high number of patients awaiting follow-up who were significantly delayed in receiving their follow-up appointment and were on the outpatients waiting list. This had been on the service risk register since 2009, but as a result of a serious incident requiring investigation that occurred as a result of this backlog, it was escalated to the trust risk register in April 2013. This waiting time had been reduced but the number of patients waiting was still significant.

Overall outpatient letters were timely. However, renal outpatient letters were taking over five weeks to be typed and sent to the patient's GP. This caused significant delays in GPs receiving updated information regarding their patients' treatment.

Easy-to-read information was available in the diagnostic department although not in other outpatient areas. The trust telephone interpreter service was not used widely by all specialities and some departments were unaware of this service. There are no signs or leaflets available in other languages.

Service planning and delivery to meet the needs of local people

- In rheumatology, the rapid access clinic was available two to three days a week. Patients were able to access services in a number of ways: GP letter (which consultants look at directly), emails and phone calls from GPs, directly from the emergency department (ED) or the acute medical unit (AMU) and through a nurse-led helpline. The clinic was responsive and could offer

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patients same-day appointments to fit in with their existing commitments, depending on their symptoms. Within three months, this service halved the rheumatology inpatient bed days.

- In diagnostic imaging an extended working day was in operation. This was introduced to offer appointments outside working hours and meet the six-week national diagnostic target, which was significantly higher (worse) than the England average (between April 2014 and July 2014). The changes were to be evaluated in April 2015, but the trust had met the target from September 2014 to January 2015. The respiratory clinic did not have a waiting list, and could provide separate clinics where patients were able to be seen within a same-sex environment.

Access and flow

- 8% of patients arranged their appointments under the NHS Choose and Book national electronic appointment system. This is significantly lower than the England average. Steps were being taken by the trust to increase the number of GPs booking patient appointments in this way, by utilising two GP champions who were chosen to promote the service among their GP colleagues. The system is to be renamed e-referral.
- 'Did not attend' rates were significantly lower than the England average. Phone calls and texts were used to remind patients of appointments.
- The referral-to-treatment target of 95% of patients who were waiting less than 18 weeks to start treatment that did not involve an admission (non-admitted pathway) was being met overall. However, there were specific areas that were not achieving this; for example, the colorectal surgery clinic waiting time was 26 weeks, trauma and orthopaedic back clinic 28 to 30 weeks and gastroenterology clinic 19 weeks. The trust had identified these waits and had taken steps to reduce them. Including recruiting additional locum medical cover and escalating the risk to the executive team. In diagnostic imaging, the trust performed worse than the England average to see patients within six weeks between April and August 2014. The trust met this target from September 2014 to January 2015.
- From April 2014 to January 2015, the trust was meeting the cancer waiting time target to see patients within two weeks.
- Waiting times for patients on arrival in the outpatient clinics varied. Current waiting times were available on a

noticeboard in some clinics, but not all. Patients told us that they often wait a number of hours in the hospital to see the consultant. At the time of inspection, the trust did not keep data on the number of patient waiting over the standard time of 30 minutes. (This standard is not being measured from April 2015),

- The trust keeps figures of the numbers of patients waiting for a follow up appointment through the outpatient waiting list. However this does not part of the integrated performance report. There were long waiting times in colorectal, orthopaedic and gastroenterology specialities but these were not defined in performance reports. In February 2015, the number of follow up patients waiting beyond their due date was 646 colorectal patients, 1,032 gastroenterology patients 871 Orthopaedic patients.
- The longest waits for a follow up appointment were in ophthalmology. In ophthalmology there were approximately 1,500 patients on the outpatients waiting list who have been delayed in receiving a follow-up appointment. This figure had been reduced from 4,000, and incorporated patients who did not attend an appointment or cancelled an appointment twice, which removed them from the list. A consultant was employed to deal directly with the patients who were on the outpatients waiting list and to see some new referrals. This issue was on the trust risk register. An amendment to the joint access policy had been formulated and agreed by the clinical commissioning groups to begin a validation process of the existing 1,500 patients awaiting follow-up. To reduce the list further, a letter was going to be designed with information advising patients to go back to their GP. This would remove patient names from the outpatients waiting list if they were 'did not attends' or cancellations by patients. It would not be sent to patients deemed vulnerable or to paediatric patients.
- Renal outpatient letters were currently taking 35 days to be typed because they used a different IT system to the rest of the hospital. The department was applying for additional IT licences and the backlog was to be dealt with by an outsourced typing service. However, they were currently at full capacity and this delay was unlikely to change in the immediate future. The trust stated that this delay had not affected patient care because urgent letters were typed by the renal medical secretaries. However, this still caused significant delays in GPs receiving updated information regarding their patients' treatment.

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Meeting people's individual needs

- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. However, in the dialysis unit on the Isle of Wight, patients attending for outpatient appointments had to walk through the dialysis unit where patients were receiving treatment in their beds to attend their consultations. In ophthalmology at Queen Alexandra Hospital, patients receiving treatment (pupil dilation) were being treated in a room that was glass walled, enabling any person walking by to observe a patient being treated.
- All staff demonstrated a good understanding of making reasonable adjustments for patients with additional support needs. This included offering a pager to patients who were distressed to allow them to leave the waiting area and then be paged when their clinician was ready to see them. Patients were offered other rooms to wait in if they felt overwhelmed by waiting in a busy reception area.
- Dementia champions were available in outpatient departments throughout the trust: they were trained to support colleagues and use their enhanced skills to assist patients with additional needs. Staff were able to stay with individual patients when staffing levels permitted.
- In radiology, easy-to-read leaflets were available for patients with a learning disability, where language style had been adjusted and pictures used to explain procedures. We did not find easy-to-read leaflets in outpatient clinics.
- The trust has a telephone interpreter service that some staff told us works well. It is not used widely by all specialities and some departments were unaware of this service. There were no signs or leaflets available in other languages.

Learning from complaints and concerns

- There was clear evidence that patient feedback was sought and welcomed across outpatient services. Comments cards, leaflets and surveys were circulated and audited throughout. Most outpatient and diagnostic imaging staff told us that patients mainly complained about waiting times for their appointments. There was no evidence of how this could be improved.

- Nursing and radiography staff gave good examples of learning from complaints and concerns.

Are outpatient and diagnostic imaging 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'.

Outpatient services did not have a strategy, but priority areas were recognised as improving capacity and maintaining appropriate staffing levels. Risks were managed under separate clinical service centres and risk registers and action was being taken. There had been learning from serious incidents requiring investigation that had improved how risks were escalated. Waiting lists were monitored and the quality of the service was being measured.

Most staff told us that they felt supported by their immediate line managers and senior management team. However, some did not feel supported by their managers and some felt their concerns were not acted on. Most staff felt that the chief executive officer (CEO) provided a strong visible presence within the trust but were unfamiliar with other board members.

The trust was currently carrying out administration review to improve services throughout outpatients as a whole. It hoped to streamline all outpatient administrative services to provide a more corporate response, rather than each speciality's administrative function working in isolation.

Staff were familiar with the trust-wide vision and values and felt immensely proud of the trust and what it was achieving. Patient engagement meetings were held within the trust. Staff told us that one of these meetings contributed to the outpatient administration review being held. In rheumatology their patient education conferences showed great innovation. A 'Love your bones' conference was held annually and offered health education and support to patients.

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Many staff were concerned about the 'borrowing' of staff from one speciality to another to meet staff shortages and the lack of planning and monitoring around this to support services. In oncology, there was a shortage of consultants in a particular specialty and contingency plans were not in place if the consultant could not attend a clinic.

Vision and strategy for this service

- Staff were clear about the trust-wide vision and values. However, there was no clear strategy for outpatients as a whole, with each speciality working independently. The trust had identified that improvements were required across the outpatient pathway and a specific project has been established to address this.
- Most staff felt that improving capacity was their greatest concern, followed by maintaining appropriate staffing levels in each department.

Governance, risk management and quality measurement

- Outpatient specialities were linked to a group and each specialty group had a risk register. Risks and performance were managed by these business teams, rather than outpatients as a whole service.
- The trust was demonstrating that they wanted to robustly address risk and improve services. The outpatient department held a weekly meeting for waiting list assurance. Each business manager attended to ensure representation from all specialities. Issues with capacity and the outpatients waiting list were discussed to improve waits for patients. Many members of staff commented that they were updated following governance meetings, either from their own senior sister or matron, or directly through their business manager by email.
- There had been learning as a result of a serious incident requiring investigation (SIRI). For example, some outpatient waiting lists had demonstrated long waiting times. Although these were on service risks registers this had not been escalated to the trust risk register until after a SIRI in Ophthalmology. Staff explained how lessons had been learnt from the serious incident requiring investigation to escalate risk so that more effective action could be taken.
- In oncology outpatients, there was one specialism that was only covered by one consultant. There were no contingency plans in place to cover the patients

requiring this specialism if this consultant were to be unavailable. There was no evidence to suggest that this issue had been addressed in any way in planning for the future.

- Quality was measured by survey, comments cards, audits and engaging patients in patient experience meetings, where outpatient representatives would listen to patients with a view to improving services.

Leadership of service

- Many staff spoke highly of the trust leadership programme. One senior nurse told us that she felt "really valued as a manager within the trust".
- Most staff spoke highly of their immediate line management. They frequently told us that they were well supported, encouraged to develop and felt valued by their own business service and the trust as a whole.
- Some senior nursing staff felt that they were not well supported by their head of nursing, occasionally feeling quite isolated in decision-making processes that were perhaps beyond their responsibility level.
- Outpatient staff felt able to give feedback to their immediate managers but not all staff felt that it would be acted on.
- Staff told us that the CEO was a real presence within the trust. She was said to be approachable, knew what was going on at grass roots level and did many walkarounds within various departments. Staff told us they did not feel that other members of the board were visible within the trust.

Culture within the service

- In all outpatient departments it was observed that there was a sense of pride among staff who worked for the trust. Many staff had been employed by the trust for a long time and felt that it played a big part in the local community. Many staff told us they had been treated at the trust as a patient, or that their families had been, and they could not fault the care they received.
- Staff demonstrated supportive relationships with their colleagues. Staff told us they felt that their working environment and team support was the main reason they remained with the trust, because it enabled them to provide better care to patients.

Outpatients and diagnostic imaging

- During our discussions with staff it was apparent how dedicated they were in providing high-quality care for their patients. Staff considered quality to be everyone's responsibility and they supported each other to ensure the best possible outcome for patients receiving care.

Public and staff engagement

- In each department we inspected there was clear evidence of feedback cards, comments leaflets and patient surveys available to patients to voice their opinions. Staff were observed verbally encouraging patients to make their opinions heard.
- Staff were encouraged by their line managers to complete the staff survey but had not received feedback on the trust's results.

Innovation, improvement and sustainability

- The outpatients service was undergoing an administration review. The review was initiated by the finance director and as a result of patient engagement meetings. A project group had been established and areas of concern identified. The review was in place to understand and quantify the size of the patient requirement. Workstreams had been identified following review, the expectation was that the outpatient administration function could be better managed to improve the outpatient experience in relation to waiting times. This project was in its infancy and auditing outcomes had not yet been defined.
- The patient education conferences offered by rheumatology and the home dialysis service both provided innovative and award-winning services to patients.

Outstanding practice and areas for improvement

Outstanding practice

- A 'Coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, provide peer support and education. Patients were also given information about support available in the community.
- There were good arrangements for meeting the needs of patients with a learning disability, particularly in theatres. The staff showed good awareness of the specialist support that patients with complex needs sometimes require. Staff used a specialist pain management tool for assessing pain levels in patients who could not verbally communicate their experiences of pain.
- The trust had developed bespoke safeguarding training modules to meet the specific needs of staff and their working environments. For example, there was safeguarding training specific to the issues identified for staff working in theatres and specific types of wards.
- The practice of daily safety briefings on the intensive care unit (ICU) ensured the whole multidisciplinary team were aware of potential risks to patients and the running of the unit.
- In the ICU there were innovative approaches to the development and use of IT systems and social media. Secure Facebook and Twitter accounts enabled staff to be updated about events affecting the running of the service. This included information about risks, potential risks and incidents. Electronic 'Watch out' screens in the unit displayed information about incidents and the unit's risk register. The education team advertised information about training opportunities on the education Twitter account.
- In the ICU, innovative electronic recording systems supported the effective assessment and monitoring of patients.
- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time and the outreach team to monitor patients on all wards and prioritise which patients they needed to attend to. This early warning system was developed in response to delayed care in deteriorating patients. Its adoption has saved over 400 deaths, and overall has reduced our mortality levels by 15%.
- Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.
- In most critical care services, beds are positioned to face into the ward. On some units beds were positioned so that conscious patients could look out of window. Queen Alexandra Hospital's critical care unit had learnt that some patients were frightened when they could not see into the ward and wanted to be able to see into the unit for reassurance. In response, the unit had equipment that could position by beds at an angle so patients could see out of window as well as into the unit.
- In response to difficulties recruiting middle-grade (registrar) doctors, the ICU in partnership with the University of Portsmouth was developing a two-year course in Advanced Critical Care Practice (ACCP). The planned outcome from this course was that ACCPs would be employed in the unit to fulfil some of the medical tasks and release medical staff to do more complicated work. This was the first initiative of this kind in the UK.
- To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the ICU had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care team in the ED, before admission to the unit. The same practice was followed for patients requiring admission to the unit from the general wards.
- The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.
- The critical care unit had developed their own innovative website that included educational information and guidance documents. There was

Outstanding practice and areas for improvement

guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.

- A perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation.
- There was a telephone scheme for women who had experienced complex or traumatic deliveries to talk about and have a debrief conversation with a midwife following their discharge. The outcomes from the conversations were used as part of the governance processes and this demonstrated a reduction in the number of complaints.
- An mobile telephone application (app) had been developed by the trust and the Chair of the Midwife Liaison Committee together with women who used the services. The app provided information on choices of place of birth and was being developed to include additional information. The app won an award from NHS England in the excellence in people category and the service had also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- The multidisciplinary team in the children's and young people's services had made a commitment to creating

an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families. We found all staff, at all levels, were involved in working towards this goal and this was having a positive impact on improving the safety and quality of services for children, young people and their families.

- There was a new initiative called a 'talent panel', which was a mechanism to discover and develop staff, both for individual career development and the future sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified.
- The trust had introduced a volunteer programme for people who wanted to work as a chaplain's assistant. Volunteers were trained on how to support patients through visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust received a national award for clinical research impact. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients. The trust identified the development of the early warning system, mobile application for pregnant mothers (cited above), and developing methodologies to reduced respiratory exacerbations and admissions and detect upper and lower gastrointestinal cancer more effectively.

Areas for improvement

Action the hospital MUST take to improve

- Patients are appropriately assessed and monitored in the emergency department (ED) to ensure they receive appropriate care and treatment.
- Ambulance patients are received and triaged in the ED by a qualified healthcare professional.
- There are effective system to identify, assess and manage the risks in the ED.
- There is an adequate supply of basic equipment and timely provision of pressure-relieving mattresses.

- The cardiac arrest call bell system in E level theatres is able to identify the location of the emergency.
- Medication is prescribed appropriately in surgery and is administered as prescribed in gynaecology.
- The emergency resuscitation trolley on the gynaecology ward is appropriately checked.
- Appropriate standards of care are maintained on ward E3 and the acute medical unit.
- There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.

Outstanding practice and areas for improvement

- Patients' bed moves are appropriately monitored and there is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night, several times and for non-clinical reasons.
- Patients are allocated to specialist wards, when clinical need requires this, and medical outliers are regularly reviewed by medical consultants.
- Nurse staffing levels comply with safer staffing levels guidance.
- There are adequate numbers of medical staff on shifts at all times.
- All wards have the required skill mix to ensure patients are adequately supported by competent staff.
- The falls action plans are followed in a consistent way across the medical services.
- There is compliance with the WHO Surgical Safety Checklist.
- Staff awareness of standard protocols or agreed indicators for pre-assessment improves to support them in making decisions about the appropriateness of patients for day case surgery.
- Staff on all wards are able to raise concerns above ward level, particularly when this impacts on patient care, and there is a response to these concerns.
- Discharge summaries are sent out in a timely manner and include all relevant information in line with Department of Health (2009) guidelines.
- Staff observe recognised professional hand hygiene standards at all times.
- The surgical high care unit is risk-assessed for infection control risks.
- Medical and dental staff complete mandatory and statutory training.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Nursing handovers provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.
- Nursing staff are appropriately trained in the safe use of syringe drivers.
- All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded.
- Patient confidentiality is protected so that patients and visitors cannot overhear confidential discussions about patients' care and treatment.
- Records are kept relating to the assessment and monitoring of deteriorating patients in recovery.

- Patient records and drug charts must be complete and contain all required information relating to a patient's care and treatment.
- Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.
- Patient records are stored so that confidentiality is maintained.
- The trust fully participates in all national audits for which it is eligible on end of life care.
- Action is taken to improve the leadership where there are services and ward areas of concern.

Action the hospital **SHOULD** take to improve

- Drugs trolleys are not left open or unsupervised in patient bay areas.
- Medicines reconciliation is based on one or more sources of information to determine which medicines an individual patient has been prescribed outside the hospital and still requires while in hospital.
- The 'This is me' booklet for patients living with dementia is used appropriately by staff.
- There is a 'flagging' system for identifying patients with a learning disability.
- Patients are able to take the medicines they are given and do not have problems opening medication packaging.
- Staff are aware of protocols for recording opening or expiry dates on part-used medicines.
- Pharmacists initial all changes to patient prescriptions.
- Staff in surgery understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Clinical governance arrangements include Ministry of Defence staff so these staff are aware of quality and safety issues when working on wards.
- The need for a dedicated dietician is reviewed on the intensive care unit.
- Patient clinical details are recorded in a clear and consistent manner so that there is no risk of information being missed.
- Documentation regarding fluid intake and output, and comfort rounds (or intentional rounding), is appropriately completed to demonstrate that care is delivered.

Outstanding practice and areas for improvement

- The trust continues to review consultant cover on the obstetric consultant-led unit so that this is in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth (2007) recommendations.
- Physiotherapy services to patients on the consultant-led obstetric unit are reviewed so that patients do not experience delays in accessing physiotherapy care and treatment.
- An accredited acuity tool is used to accurately assess nurse staffing levels required to care for medical and high dependency patients on the wards.
- Security arrangements are sufficiently robust to avoid visitors 'tailgating' into the paediatric unit out of hours, or to gain access to the children's assessment unit.
- Protocols for the treatment of diabetic ketoacidosis for young people are standardised across the hospital.
- There are appropriate facilities for teenagers admitted to the wards, and accommodation is provided in bays with patients of a similar age.
- Access arrangements to the neonatal unit are sufficiently responsive out of hours when nursing staff are busy caring for neonates.
- Arrangements for psychological and emotional support for children and young people with non-acute mental health needs is reviewed.
- The bleep holder's folder contains current information that is clear to read and easy to find.
- Services have detailed strategic plans for service developments, for example, for the single point of access and appropriate provision of high dependency services.
- Action is taken on the workload of the bereavement support service in response to the external assessment undertaken by the local clinical commissioning group.
- Patient information is available in an easy-to-read format.
- Patients are given information about how to make a complaint and what responses they should expect to receive.
- There are end of life care link nurses on wards and the link nurses are given time and support to be the champions of end of life care.
- The layout of the ophthalmology outpatient department and location of visual acuity tests is reviewed so that patients' privacy and dignity is maintained during treatment.
- Patients attending for renal outpatient appointments on the Isle of Wight do not walk through the dialysis unit where patients are receiving treatment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 HSCA Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service.</p> <p>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.</p> <ul style="list-style-type: none">• The medical outliers were not regularly reviewed by medical consultants.• Patients were not allocated to specialist wards according to their clinical needs.• Nursing handovers did not provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met. <p>Regulation 9- 1 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p>

Compliance actions

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

The provider did not have effective systems to regularly assess and monitor the quality of services provided.

- Patients were not appropriately monitored and were moved several times and at night and for non-clinical reasons.
- Staff were not aware of standard protocols or agreed indicators for pre-assessment improve to support them in making decisions about the appropriateness of patients for day case surgery.
- Some nursing staff on wards did not feel safe in raising concerns above ward level.
- GP discharge summaries were not being sent out in a timely manner and did not include all relevant information in line with Department of Health (2009) guidelines.
- The surgical high care unit had not had a risk assessment for infection control risks.

Regulation 10 (1) (a) (b) (HSCA 2008 (Regulated Activities) Regulations 2010.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

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.

Compliance actions

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.

- There were inadequate supplies of intravenous pumps, drip stands, pressure-relieving mattresses and other equipment.
- The cardiac arrest call bell system in E level theatres was unable to identify the location of the emergency.

Regulation 16 1 (a) (2) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20. HSCA 2008 (Regulated Activities) Regulations 2010 Records.

The registered person must ensure that the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of – (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

- The falls action plans were not followed in a consistent way across the medical services.
- Compliance with the WHO Surgical Safety Checklist was not documented appropriately.
- Records relating to the assessment and monitoring of deteriorating patients in recovery were not kept.

Compliance actions

- Patient records and drug charts were not complete and did not contain all required information relating to a patient's care and treatment.
- Patient records were not always stored so that patient confidentiality was maintained.
- Do not attempt cardiopulmonary resuscitation forms were not completed appropriately.

Regulation 20 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff at all times.

- Nurse staffing levels did not comply with safer staffing levels guidance.
- All wards did not have the required skill mix of staff to ensure patients are adequately supported by competent staff.
- Medical staffing levels were not as recommended.

Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

Regulation 23: HSCA 2008 (Regulated Activities) Regulations 2010: Supporting Workers.

- Medical and dental staff did not meet trust targets to complete mandatory and statutory training.
- Nursing staff did not receive formal clinical supervision in line with professional standards.
- Nursing staff did not have appropriate training in the safe use of syringe drivers.

Regulation 23 1(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 HSCA Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service.</p> <p>A warning notice was served under Regulation 9 1 (a) (b) In the Emergency Department</p> <p>Patients brought to the emergency department by ambulance were at risk of unsafe care and treatment. The trust had failed to take proper steps to ensure that each service user is protected against the risk of receiving care or treatment that is inappropriate by the means of carrying out an assessment of the needs of the service users and planning and delivering care in a timely way to meet the individual service user's needs. The trust did not take proper steps to ensure the welfare and safety of service users.</p> <ul style="list-style-type: none">• National guidance was not followed in the triage and assessment of patients.• A national target had been set that states that ambulance patients should be handed over to the care of emergency department staff within 15 minutes. Figures sent to NHS England showed that the average waiting time to initial clinical assessment by the emergency department at Queen Alexandra Hospital was 25 minutes.• Patients waiting in corridors did not have appropriate monitoring and observation.• Patients who did not receive clinical assessment within 15 minutes were not receiving care or treatment to meet their individual needs and to ensure their welfare and safety. Some patients with serious conditions had been waiting over 60 minutes.• A non-healthcare professional was being used to triage patients.

Enforcement actions

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

Regulation 10 HSCA Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision

A warning notice was served under Regulation 10 1 (a) (b) 2 (c) In the Emergency Department

- The trust's identified problem with flow had been on the risk register since November 2014.
- The recommendations from the Emergency Care Intensive Support Team report (May 2014) had not been implemented. There was a draft and incomplete action plan in August 2014.
- The emergency access target was not met and was identified as a major risk on trust risk registers.
- Escalation plans did not have sufficient triggers and actions to manage the problems with flow in the emergency department.
- The trust had not clearly defined the responsibility with the ambulance service for patients on hospital grounds and patients were at risk.
- Staffing levels had not been reviewed in line with changes made to the department.
- Changes to the department had been introduced that did not meet national guidance (a healthcare assistant triage process).
- At our unannounced visit no progress had been made following the inspection.
- The trust had introduced a method to monitor assessment but the process made staff feel 'pressurised' and provided false assurance.