University Hospital Southampton NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospital Southampton NHS Foundation Trust has had foundation trust status since 1 October 2011. It provides services to 1.3 million people living in Southampton and south Hampshire, as well as specialist services to over three million people living in southern England and the Channel Islands. Deprivation in the City of Southampton is higher than average (79 out of 326 local authorities). The surrounding areas of Eastleigh, Fareham, New Forest and Test Valley are less deprived. The trust is also a major centre for teaching and research, in partnership with the University of Southampton, the Medical Research Council and the Wellcome Trust. The NHS trust has approximately 1,372 beds and over 10,000 staff.

The trust includes Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House, and also runs outpatient services from the Royal South Hants Hospital.

We carried out this comprehensive inspection as part of our programme of inspecting and rating acute hospitals. The trust had not been flagged as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. We inspected urgent and emergency care, medical care (including older people's care), surgery, critical care, maternity and gynaecology services, services for children and young people, end of life care, outpatients and diagnostic services.

For specific information about services, please see the reports on Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House. Outpatients services at Royal South Hants Hospital are noted in the outpatients and diagnostic imaging section of the Southampton General Hospital report.

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

We rated A&E, medical care, maternity and gynaecology, and children and young people's services as 'good' and surgery, critical care, end of life care, and outpatient and diagnostic services, as 'requires improvement'. Countess Mountbatten House was rated as 'good'.

Our key findings for the trust were as follows:

Is the trust well-led?

- The trust had a vision and clinical strategy for 2020 that had been written eight years ago. This was being refreshed to take account of its key tenets, and to provide a more up-to-date strategic vision on excellence in healthcare, working in partnership and supporting innovation. Current strategies and plans were dealing with the immediacy of the increasing demand for services, and balancing quality, targets and finance was a serious challenge. The trust was having to take difficult decisions on long-term goals to ensure sustainable services.
- Governance arrangements were well developed at trust, division, care group and ward level. The trust had a comprehensive integrated performance report to benchmark quality, operational and financial information. Clinical quality dashboards were being developed from board to ward, to improve the quality of information, monitoring and reporting. Risks were appropriately managed and escalated to the board overall, although this did not happen in a few areas, and the actions taken on a few risks were not always timely. Safety information was displayed in ward and clinic areas for patients and the public to see.
- The leadership team showed commitment, enthusiasm and passion to develop and continuously improve services. The trust identified a challenging patient improvement framework, and could demonstrate some improvements, if not achievement, in many areas.
- All staff at every level, told us about the visible and inspirational leadership of the chief executive. Staff were positive about working for the trust and the quality of care they provided. The trust was in the top 20% of trusts for staff engagement. There was a focus on improving patient experience, and public engagement was developing to ensure the public had jargon free communication; there was consultation on services, and patients would be told how their feedback was used to improve services.

Summary of findings

- The trust had a culture of innovation and research, and staff were encouraged to participate. There were examples of research that were nationally and internationally recognised. Staff were supported to lead innovation projects in their work environment.
- Cost improvement programmes were identified, but savings were not being delivered as planned. The trust was taking further action to reduce the risks of financial deficit but maintain quality.

Our key findings for the trust's services were as follows:

Are services safe?

- National data indicated that the trust was reporting more incidents than the national average. Staff were encouraged and found it easy to report incidents on the electronic system. The greatest proportion of incidents were low and no harm incidents. Slips, trips and falls was the top serious incident requiring investigation (SIRI) and action was being taken to reduce falls across Southampton General Hospital. We found that incidents were investigated and learning shared within services, but learning across services, such as outpatients, could be improved. The reporting of incidents in diagnostic imaging services was not always robust and transparent.
- In most services there was a culture of openness and transparency when things went wrong, and the trust was well placed to meet the new regulations relating to Duty of Candour.
- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, venous thromboembolism (VTE or blood clots), catheter urinary tract infections (C. UTIs) and falls. The information was monitored throughout the trust and the results were displayed for the public to see in clinical areas. Falls were starting to reduce and C. UTIs were consistently low.
- The hospital was working to reduce the prevalence of pressure ulcers incrementally over time. The trust had a target to reduce occurrences by 20% over the year; this had not been fully achieved in 2013-14. Hospital data indicated there was a slightly decreasing trend for avoidable grade 2, 3 and 4 pressure ulcers by the end of 2014.
- The trust had a zero tolerance for hospital infection rates for MRSA. MRSA rates were higher when compared to trusts of similar size and complexity, but there had been no cases since July 2014.. The trust's infection rates for C. difficile were lower when compared to trusts of similar size and complexity.
- The hospital was visibly clean and patient-led assessments of the care environment (PLACE) scored higher than the national average for cleanliness. Cleaning services were outsourced, but domestic staff were seen to be part of the ward teams.
- During the inspection in December 2014, there was an outbreak of Norovirus and appropriate action was taken to control and contain this, through closure of wards and bays. We observed, however, that not all staff were consistently following trust infection control policies in relation to hand hygiene; this was a concern given the outbreak. We brought this to the attention of senior management and at an unannounced inspection in January 2015 we found improved practice. There were good infection control and hand hygiene practices at the Princess Anne Hospital.
- Safeguarding processes to protect vulnerable adults, children and young people were embedded.
- Staff had access to a range of mandatory training, and attendance was monitored electronically. Mandatory training on end of life care had not yet been implemented.
- Most medicines were managed and stored safely, but some medicines needed better secure storage in theatres. In ophthalmology, a patient specific direction was developed under a patient group direction and healthcare assistants were administering eye drops. This was not in line with the medicines legislation and best practice guidance.
- Some parts of the buildings were constructed before the current building guidelines for health facilities were established, and this, along with the increased activity at the hospitals, resulted in some areas being cramped and outdated, including the emergency department, the Princess Anne Hospital, some children's wards, and the general intensive care unit (GICU). There were also safety concerns about deficiencies in maintenance, particularly in older parts of the building.
- Most services were well equipped, but there were shortages of some basic equipment across some wards and departments. There were also some delays in the provision of pressure relieving equipment, as the

external company who were supplying it were unable to meet demands. Maintenance and checking of equipment was not undertaken regularly in some areas.

- At the Princess Anne Hospital, hoisting equipment was available on Bramshaw Ward. But not all staff were aware of the location or correct use of equipment for the safe evacuation of a woman who may have collapsed in a birthing pool, on either the delivery suite or at the Broadlands Birth Centre. One of the four operating tables could not be lowered adequately and surgeons were required to stand on stools, which increased both the risk of back injuries to the surgeon and also patient risks during surgery. At the time of the inspection there was one bariatric table in use so two theatres were not compliant
- Episodes of interruption to the electrical power on GICU interfered with lighting and with the continuous functioning of some equipment, such as monitors.
- The siting of a gamma camera outside of the confines of the nuclear medicine department created a potential radioactive hazard. Mitigating actions had been put in place, but further action was needed to remove the risks.
- Nursing staffing levels had been reviewed and assessed across the hospital using the Safer Nursing Care Tool. High levels of vacancies were impacting on consistency of staffing to the required levels. Staffing levels were reviewed on a shift-by-shift basis and staff moved across wards to try to mitigate risks; however, this led to concerns about lack of continuity and relevant skills to meet the needs of patients of different specialties. This was accentuated by the high number of, particularly medical, outliers (patients not on medical wards) across the hospital due to high demand and insufficient capacity.
- Funded midwife to birth establishment was 1:28 in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations. However, with sickness and maternity leave the current ratio was 1:31, which was below than the England average of 1:29. There were core midwives who were allocated to different areas. Midwives then followed women to provide their care. As a result, midwives reported frequent moves to different work areas. Most movement occurred in order to provide one-to-one care to women in labour. As a result, midwifery staffing on the ante- and postnatal areas was, at times, below the recommended numbers. This resulted in the care of women in these areas being delayed.
- Low staffing levels in diagnostic imaging services, in particular radiographers, was having an impact on safety.
- Medical staffing was at safe levels in most services and there was an innovative model of 'lead consultant for out-of-hours' (work). However, there was not an interventionist in the neuro intensive care unit (NICU) at night for patients who need critical care treatment, including respiratory support. There was insufficient medical cover, particularly at consultant level, for end of life care services across the hospital.
- The trust reported 98 hours dedicated consultant cover on the delivery suite, which fell below the recommended 168 hours of consultant presence to meet the recommendations of the RCOG Safer Childbirth (2007). There was a separate on-call rota for gynaecology and obstetrics, which meant that medical staff were not required to provide cover to both areas.
- New end of life care plans had been introduced in August 2014 as a pilot on some selected wards. This was in response to the national withdrawal of the Liverpool Care Pathway. Not all wards where the pilot care plan had not been rolled out were aware of the guidance issued. There were concerns that without proper documentation, care provided to patients could be adversely affected.
- The modified early warning score (MEWS) was used effectively to identify deteriorating patients. Some areas, such as the children's wards, needed to improve their use of the early warning score, and clearer systems were needed for the timely referral of patients, whose clinical condition was deteriorating on the wards, to the outreach team
- Care pathways were being used to standardise care for patients who were acutely ill.

Are services effective?

- In most services care and treatment was provided in line with national best practice guideline, and outcomes for patients were often better than average. The hospital was developing end of life care in line with national guidance. The results of the 2013/14

Summary of findings

National Care of the Dying Audit of Hospitals (NCDAH) highlighted a number of areas for improvement. The hospital had since made some progress on the implementation of the action plan.

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

Are services caring?

- Staff were caring and compassionate, and treated patients with dignity and respect. The chaplaincy team were involved in undertaking a specific listening exercise on what compassionate care meant for staff working at the trust. The 10 key recommendations from this report were now being implemented across the organisation.
- We observed outstanding care and compassion in children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care. We also observed examples of outstanding care, such as from reception staff in the emergency department who, although busy and working under tremendous pressures, made considerable efforts to reassure, inform and direct people presenting to them. Also, the emotional support for patients and relatives in critical care, and the patience and understanding of staff on the older people's wards.
- Patients and their relatives described the care and treatment at Countess Mountbatten House as "excellent". There was a strong commitment to, and support for, the patients and their relatives, both before and after death. Patients were treated with compassion and care. They were put at the centre of their care through ongoing consultation and the involvement of their relatives.

Summary of findings

- Patients told us their experiences of care were good. The average response rate of the trust for the NHS Family and Friends Test (FFT) was above the England average. Between April 2013 and March 2014, 73.6% of patients were 'extremely likely' to recommend the trust to family and friends.

Are services responsive?

- Bed occupancy at the trust was 92% (January 2013-March 2014), consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. The trust had been operating at near 100% occupancy (measured at midday) in the months leading up to and during the inspection. Adult critical care was at 89.36% bed occupancy – above the England average of 83.24%. In the months leading up to and during the inspection, bed occupancy in the units was between 90% and 100%.
- Despite the best efforts of staff at all levels of the trust to monitor and maximise use of available capacity, high demand was having an impact on access and flow throughout the trust; for example, patients admitted for elective surgery, who required planned critical care beds, were remaining in theatre recovery areas for lengthy periods of time until critical care beds became available, resulting in admissions to the units during night hours.
- There were two fully staffed obstetric theatres from 8am-1pm every weekday. At all other times one theatre was available for emergencies and a second team available to be called upon if needed. There were some delays for non-emergency procedures, such as the repair of third and fourth degree perineal tears, these had reduced since the opening of a second theatre in the mornings.
- The trust was meeting the national target for 92% of patients to be waiting 18 weeks or less, from referral to treatment (incomplete pathway). There was, however, a backlog of patients waiting for surgery, and the trust was not meeting the national target for 90% of patients to actually be treated within 18 weeks (admitted pathway). The trust could demonstrate that it was focusing on the longest waiting patients, and those with complex and urgent cases for surgery. Performance against this target was improving; for example, increased theatre use had improved waiting lists in trauma and orthopaedics.
- Emergency admissions impacted on capacity, and were adding pressure to services. The lack of available beds was resulting in cancelled operations and patients spending longer periods in the theatre recovery areas while waiting for a bed. The trust had improved performance over the year on reducing cancelled operations, and for patients with cancelled operations being treated within 28 days, but was still not meeting national targets.
- The number of non-clinical cancellations increased at the end of the year, when Southampton General Hospital was experiencing extreme capacity issues and was on 'black alert'. For example, there were 27 non-clinical cancellations for the week ending 10 August 2014; this increased to 55 for the week ending 7 December 2014. Systems were put in place to prioritise operations that should go ahead each day and to give patients as much notice as possible of any cancellations.
- The trust was now meeting the two week cancer waiting time target for referral from a GP to see a specialist. The trust was also meeting the 31 day target from diagnosis to definitive treatment, although this was below the England average for cancer waiting times. The trust was not meeting the target for people to be waiting less than 62 days from referral to start of treatment. There was a detailed cancer recovery plan, which included seeking specialist external advice from the NHS Interim Management and Support Team.
- The trust was not meeting the national referral to treatment target time for 95% of patients to be referred and treated within 18 weeks for outpatient services. In some outpatient services clinic hours were being extended to evenings, and also run on a Saturday, to improve access. Waiting times for patients upon arrival in the outpatient clinics varied. Some patients could wait for several hours to be seen in some clinics, and were warned in advance of this possibility.
- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged, but

are unable to leave the hospital due to external factors. During our inspection, 200 (16%) medical patients and 54 (6%) surgical patients had a delayed transfer of care. The main cause of delay was the provision of community services, especially care home places, to meet patients' ongoing needs, and timely social care assessments. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and on the service overall.

- The trust was not meeting its own internal targets to review and discharge patients, who were medically fit and could go home, at set times during the day. Patients were positive about the discharge lounge and this was working well, but this was only used for medical patients.
- The trust steering group was set up to improve discharge arrangements. This included plans to commence discharge on admission, and for patients to have an estimated date of discharge and a best interest assessment within 48 hours. Patients would be allocated for fast track, simple or complex discharge as soon as possible, and assessment and management would be supported by the trust's integrated discharge bureau working in partnership with commissioners, the local authorities, and the local community and mental health trusts.
- The hospital had a rapid discharge service for end of life patients to a preferred place of care. A recent trust audit (2014) had shown that 47% of patients with cancer, who were known to the specialist palliative care team, were dying at home.
- We observed mixed sex accommodation breaches on AMU 1, and on the cardiac short stay ward; this compromised privacy and dignity. The staff were reporting when patients needed to be cared for in a mixed sex bay on AMU 1, and we noted this was in line with agreements with local commissioners. But the staff on the cardiac short stay ward did not recognise these breaches. There was also a risk of mixed sex breaches in critical care services, when there were delays to level 1 patient transfers to wards.
- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients living with dementia or those who have a learning disability. We found examples of adjustments made for patients with a learning disability in outpatients and diagnostic imaging, and in surgical services.
- The hospital had implemented an interpreter service. They also encouraged staff with existing foreign language skills to participate in a training programme, enabling them to qualify as an interpreter.
- There were various printed information leaflets available to patients and their relatives across the trust. All information for patients was only available in English. Patients could request information to be made available in another language, but that request leaflet was also only published in English, making it highly unlikely that a patient who spoke another language could access the information in their own language. We did not see any information in an easy-to-read format.
- Departments across the hospital reviewed and acted on complaints and feedback, to improve services.

Are services well-led?

- Staff were committed to the values of putting the patient at the centre of their work and were inspired by the CEO's focus on this. They were aware of the trust's vision and had started to be involved in discussions about updating the trust strategy.
- In most services the departmental strategy and vision was recognised by staff. Staff in some departments were not aware or confident that there were clear plans and strategies to address some significant concerns in a timely way.
- There were governance systems in place to identify risks and for quality monitoring. But in some services there was a disconnect between the risks and issues described by staff and those reported to and understood by senior management and the board. These included pressures on service capacity, staffing levels, and the safety of outdated and cramped clinical environments. The trust had taken mitigation actions around the environmental risks.
- Across services, staff reported a strong supportive leadership from matrons, senior sisters and lead clinicians. They told us the CEO and senior management team communicated effectively with staff at all levels.

Summary of findings

- Staff were positive about working at the hospital and would recommend it as a place to work despite the challenges. Across the hospital, there was an ethos of openness and transparency, and collaborative multidisciplinary working.
- There was a strong commitment to research in a clinical environment supported by research nurses.
- Innovative practices were encouraged.
- The hospice (Countess Mountbatten House) had a dedicated staff team, with clear visions and values. Staff commented “we work as a team and all pull together”, in order to achieve best outcomes for the patients. There was strong clinical leadership at the hospice. There was a clear governance structure from unit level to the trust board. Members of the board made quarterly visits to both the hospice and community services. The friends and family test (FFT) was embedded but other processes for seeking the views of patients and their relatives was not fully developed. Further work with partners was needed to develop bereavement services, and a ‘hospice at home' service.

We saw several areas of outstanding practice including:

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

Summary of findings

Families were invited back to the unit to discuss their relative's treatment and death, in order for them to better understand the patient's journey and the reason why they did not survive.

- Patient profiles were obtained in the NICU to give staff insight into a patient's likes, dislikes and interests. This enabled staff to talk with the patient about subjects that would interest them, whether they were conscious or not.
- The paediatric day care unit included a nurse-led service where nurses had extended roles. These included prescribing medicines and discharging patients.
- To ensure children's voices were heard and acted upon, the day care unit had developed the 'Pants & Tops' initiative. Through this initiative, children were invited to write down on templates what had been 'tops' or 'pants' about their hospital stay. Children who were very young, and were unable to write, could still provide feedback.
- The children and young people's service used play leaders and youth support workers as advocates for children and young people. The service had an ethos of compassionate care and peer support, and social events were actively encouraged for children and for the parents of children with cancer, and long-term or chronic diseases.
- The trust had implemented a 'Ready, Steady, Go' initiative to support young people through the transition from children's to adult services. Young people were involved in deciding when they were transferred.
- The chaplaincy team held a listening exercise with staff to help identify what compassionate care meant for staff working at the trust. The 10 key recommendations from this report were now being implemented across the organisation.
- The bereavement support team were involved in the co-ordination of tissue transplantation. They explained how families could get involved, and supported families through the tissue transplant process. As a result of this service, tissue transplant donation had increased by 300% (from 20 tissue donations in 2011, to 60 donations in 2013/14).
- The Allergy Clinic within the outpatients department, had received a World Health Organization (WHO) award for excellence.
- Midwives who held a caseload (caseload midwives) worked in areas of greatest deprivation and with the largest number of teenage pregnancies. These midwives had smaller caseloads and provided greater continuity of care, and often followed the women into the maternity unit to deliver.
- There was a 'birth afterthoughts' service, which enabled women to have a debrief with a midwife following their delivery. Themes from this service were identified and fed into the governance process. Over 400 women had accessed the service during 2014.
- Women with hyperemesis could be cared for as day case patients and receive intravenous fluid rehydration. This meant they could remain at home and helped to prevent admission.
- A telephone triage service had been agreed with a neighbouring trust and was about to be implemented. This initiative would direct women to the appropriate place for care.

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

Importantly, the trust must ensure:

- Nurse staffing is consistently at safe levels, to meet the needs of patients at the time and support safe care.
- Equipment is regularly tested and maintained, and a record of these checks is kept.
- There are suitable environments to promote the safety, privacy and dignity of patients in the cardiac short stay ward, G8 ward, and all critical care areas with level 1 patients.
- There is sufficient basic equipment in all departments and timely provision of pressure relieving equipment, beds and cots.
- The access and flow of patients across the Southampton General Hospital is improved. Discharge is effectively planned and organised, and actions are taken to improve delayed transfer of care discharges.
- All wards have the required skill mix to ensure patients are adequately supported with competent staff.
- No risks are posed to patient safety in the event of electrical failures in critical care areas.

Summary of findings

- All risks associated with the cramped environment in critical care areas are clearly identified, and timely action is taken to address those risks.
- Overhead hoists in critical care units are correctly positioned and in working order, so they can be used, as intended, for patient care.
- There is an effective process embedded into practice for alerting medical staff or the outreach nursing team in the event of patients deteriorating on the general wards.
- There is appropriate management of identified risks in the general intensive care unit.
- There is a definite plan to develop critical care services to meet the local and regional population's health needs; this plan is to include the provision of appropriate follow-up services.
- The specialist palliative care team reviews the level of medical consultant support.
- There are safe staffing levels in diagnostic imaging teams to prevent untoward safety incidents occurring.
- Incidents are reported by radiographers, and there is learning from all IR(ME)R and diagnostic imaging incidents, and processes for Duty of Candour are appropriately followed.
- All maternity staff are aware of the location or correct use of equipment for the safe evacuation of women from the birthing pools.
- The operating tables in maternity theatres can be lowered adequately, so surgeons are not required to stand on stools, which would otherwise increase the risk of back injuries to the surgeon and patient risks during surgery.

As a provider, the trust should ensure:

- Continue to improve complaints handling procedures, in particular to ensure that complaint responses address all identified concerns, lessons are learnt and overdue complaints are reviewed.
- Its clinical strategy is updated and implemented.
- Transformation and strategic plans are well developed, and formal processes with commissioners and partners are used effectively.
- Clinical quality dashboards are further developed at division, care group and ward level, and there is the ability to monitor the patient improvement framework at these levels.
- Risk registers are up to date, with appropriate mitigation and controls.
- The board assurance framework is developed and reviewed, to assurance around actual, anticipated and potential strategic and operational risks.
- Director's portfolios are clear and understood by staff.
- There is better leadership in services where this is of concern, including critical care and diagnostic imaging.
- Divisions continue to work together to improve patient pathways across the trust
- The trust completes the cultural safety survey.
- The equality and diversity strategy is integrated within the trust.
- The Fit and Proper Persons Requirement (FPPR) is implemented appropriately.

Please refer to the location reports for details of where the trust SHOULD also make improvements

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to University Hospital Southampton NHS Foundation Trust

University Hospital Southampton NHS Foundation Trust has had foundation trust status since 1 October 2011. It provides services to 1.9 million people living in Southampton and south Hampshire, as well as specialist services to over three million people living in southern England and the Channel Islands. Deprivation in the City of Southampton is higher than average (79 out of 326 local authorities). The surrounding areas of Eastleigh, Fareham, New Forest and Test Valley are less deprived. The trust is also a major centre for teaching and research, in partnership with the University of Southampton, the Medical Research Council and the Welcome Trust. The NHS trust has approximately 1,372 inpatient beds and over 10,550 staff.

The trust includes Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House, and runs outpatients services from the Royal South Hants Hospital.

Southampton General Hospital has approximately 1,268 inpatient beds, over 150,000 emergency attendances, and sees over 500,000 outpatients each year. Over 8,400 staff are employed at the hospital.

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

The Princess Anne Hospital provides maternity and gynaecological services and is adjacent to the main general hospital. The trust had approximately 104 maternity beds. Midwife-led and obstetrician-led services are provided for early pregnancy assessment, antenatal, induction of labour and postnatal care. The service includes the Broadlands Birth Centre, a midwife-led unit near the main obstetrics unit, and the New Forest Birth Centre, located in Ashurst on the edge of the New Forest. Gynaecological care is provided in a 21 bedded gynaecological and breast care ward (Bramshaw), a gynaecological outpatients area, and a hyperemesis unit.

Countess Mountbatten House is a 25 bed unit providing treatment and care to adults with life limiting conditions, specialist end of life care, and support for patients and families. The hospice includes a day care unit (the Hazel Centre) which supports patients living in the community.

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Joyce Frederick, Head of Hospital Inspection

The team of 60 included CQC inspectors and analysts, and a variety of specialists, including: consultant in emergency medicine; consultant gynaecologist and obstetrician; consultant surgeons; consultant anaesthetist; consultant physicians; consultant geriatricians; consultant radiologist; consultant

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oncologist; consultant paediatrician; paediatric surgeon; junior doctors; emergency department nurses; midwife; head of maternity and gynaecology; surgical nurses; theatre nurse; medical nurses; paediatric nurses; paediatric physiotherapist; palliative care specialist nurse; critical care nurses; outpatient manager; board level clinicians; governance lead; safeguarding leads; student nurse; and 'experts by experience'. (Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.)

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider: Is it safe? Is it effective? Is it caring? Is it responsive to people's needs? Is it well-led?

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

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

We carried out announced inspection visits on 10 and 11 December 2014. We withdrew from the inspection on 11 December, as a precautionary measure, due to an outbreak of Norovirus, which resulted in closure of Southampton General Hospital to visitors. We completed the inspection through unannounced two day inspections to all services between 5 and 15 January 2015.

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

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

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

What people who use the trust's services say

- We attended a Speak Out event held at New Milton Community Centre on 4 November 2014, organised by the South East England Forum on Ageing (SEEFA). The event was attended by 18 people, four of whom had a disability. The feedback from participants was generally positive, and the New Forest Birthing Centre and the breast services at the Princess Anne Hospital were particularly praised. There was feedback on areas for improvement, and this include the co-ordination, safety and lack of follow-up and support around discharge, staffing levels particularly on the orthopaedic wards, the poor quality of food, the cleanliness of some public areas in Southampton General Hospital, and security arrangements for babies at the Princess Anne Hospital.
- We held a public listening event, on 9 December 2014. The event was attended by 10 people. People had mixed views. There were positive comments about staff being attentive and caring, and responding to concerns even when busy, the cleanliness of the

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hospitals, and good experience of care. There were negative comments about staffing levels, communication across departments to organise care, and waiting times for treatment.

- The results of the NHS Friends and Family Test (FFT) 2013/14 showed that the trust scored above the England average on the inpatient wards. The A&E scores showed that the trust was performing above the England average for all four months. Response rates were consistently better than the England average.
- The CQC adult inpatient survey (2013): The trust had performed similar to other trusts in the six areas of question on the hospital and ward, nurses, doctors, care and treatment, operations and procedures and leaving hospital. Response rates varied between wards.
- The CQC A&E survey (2014): The trust performed similar to other trusts for most questions. The trust was worse than other trusts (in the bottom 20%) for two key questions on safeguarding (if patients felt threatened by other patients or visitors while in A&E) and access and flow (if patients had waited in A&E for more than four hours).
- The Cancer Patient Experience Survey (CPES) by the Department of Health 2012/13 is designed to monitor national progress on cancer care. A total of 152 acute hospital NHS trusts took part in the 2013/14 survey, which comprised of a number of questions across 13 different cancer groups. Of 34 questions, the trust performed similar to other trusts overall. The trust was worse than other trusts (in the bottom 20% of trusts) for five questions: patients being seen as soon as they thought necessary; confidence in all ward nurses; control of the side effects of chemotherapy; patients health getting better or remaining the same while waiting; and information on patient support groups.
- The CQC Survey of Women's Experiences of Birth 2013 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth. There was one question where the trust performed better than other trusts (in the top 20% of trusts) and this was for women or their partner not being left alone by a doctor or nurse at a time when they might be worried.
- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. In June 2014, the trust scored higher than the national average for cleanliness (99%, compared to 98% nationally), privacy, dignity and well-being (92%, compared to 87%), facilities (95%, compared to 92%) and food and hydration (93%, compared to 90%).

Facts and data about this trust

University Hospital Southampton NHS Foundation Trust: Key facts and figures

University Hospital Southampton NHS Foundation Trust (UHS) has had foundation trust status since 1 October 2011

UHS has five active registered locations: Southampton General Hospital (SGH), the Princess Anne Hospital (PAH), Countess Mountbatten House (CMB), Royal South Hants Hospital and the New Forest Birth Centre.

UHS provides direct clinical services to over 727,000 patients a year. It provides services to the population (1.9 million) of Southampton and south Hampshire. It also provides specialist services, such as neurosciences, cardiac services and children's intensive care, to more than 3.7 million people in central southern England and the Channel Islands.

The Princess Anne Hospital is a level 3 neonatal intensive care unit. The number of births recorded was 5,495, with 98.5% being single births and 1.5% multiple births. This is the same as the England average. (Source: RCPCH, 2013)

1. Context:

- The trust has around 1,372 beds.
- The local population is around 500,000 of which 100% is urban.
- The number of staff is over 10,550.

Summary of findings

- The board has 0% Black and ethnic minority (BME) members representation of executive directors and 6.7% representation of non-executive directors (NEDs); it has 57.1% female representation of executive directors and 25% female representation of non-executive directors.
- Deprivation in the City of Southampton is higher than average (79 out of 326 local authorities). The surrounding areas of Eastleigh, Fareham, New Forest and Test Valley are less deprived.
- Life expectancy for both men and women is higher than the England average.
- The trusts income for 2013–14 was £614,676,000; the costs were £613,418,000.
- The trust surplus was £1,258,000 (2013/14)

2. Activity:

- Inpatient admissions 140,000 (2012-13)
- Outpatient attendances 520,677 (2012-13)
- A&E attendances 154,260 (2012-13)
- Births 5,495 (July 2013 to June 2014)
- Deaths 2,351 (April 2013 – March 2014) (SGH 1,947; PAH 53; CMB 351)

3. Bed occupancy:

- General and acute: 91.88% (January 2013-March 2015). This was consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Maternity was at 52.62% bed occupancy – consistently lower than the England average of 57.9%.
- Adult critical care was at 89.36% bed occupancy – above the England average of 83.24%.

4. Intelligent Monitoring:

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

Individual risks/elevated risks:

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

5. Safe:

- 'Never events' in past year 2 (2013/14)
- Serious incidents (STEIS) 183 (2013/14) - 42% were pressure ulcers
- National reporting and learning system (NRLS) July 2013-Dec 2014; no evidence of risk

Death 13 (0.1%)

Severe Harm 79 (0.6%)

Moderate Harm 364 (2.9%);

Low Harm 3,118 (25.5%);

No Harm 8,650 (70.7%)

Total 12,224

Safety Thermometer (July 2013–July 2014)

- Pressure ulcers – comparable to national average
- Catheter UTIs – lower than England average
- Falls – consistently higher than England average

Infection control (March 2013 – July 2014)

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

6. Effective: (December 2014)

- Hospital Standardised Mortality Ratio (HSMR): no evidence of risk (Intelligent Monitoring)

Summary of findings

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

7. Caring:

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

8. Responsive:

- A&E four hour standard – not met; below the England average (July 2013–July 2014)
- A&E – time to initial assessment: below the England average (January 2013–July 2014)
- A&E – time to treatment: above the England average, but in general, similar to standard time of 60 minutes (January 2013–July 2014)
- Emergency admissions waiting 4–12 hours in A&E from decision to admit to admission: above the England average
- A&E left without being seen: above the England average (January 2013–May 2014)
- 18 week RTT– surgery - consistently worse than 90% NHS operating standard (July 2013–June 2014)
- 18 week RTT (incomplete) – 92% of patients overall wait for surgery within 18 weeks: met (April–September 2014)
- 18 week RTT (non admitted, outpatient) – 95% NHS operating standard: not met (July 2013–June 2014)
- Cancelled operations and not treated within 28 days – above the England average (April 2011–June 2014)
- Cancer waiting times: not meeting standard for urgent two weeks (seen by specialist), 31 days (diagnosis to treatment) and 62 days treatment (urgent referral to treatment)
- Diagnostic waiting times – six weeks; standard met

9. Well-led:

- NHS Staff survey 2014 (29 questions)Better than expected (in top 20% of trusts) for 11 out of 29 questions; above average for eight questions; average for nine questions; below average for one question. Not in the bottom 20% of acute trusts for any questions (staff survey 2014)
- Use of bank and agency staff – below the England average
- Sickness rate – below the England average
- GMC National Training Scheme Survey (2013)The trust was within expectations for all areas of the National Training Scheme Survey, except for feedback – this was worse than expected

10. CQC inspection history:

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

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **By safe, we mean that people are protected from abuse and avoidable harm.**	Requires improvement 

Overall, we rated the safety of the services at the trust as 'requires improvement'. For specific information, please refer to the individual reports for Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House.

The team made nine separate judgements about the safety of services in the trust. Six were judged as 'requiring improvement' and three were judged as 'good'. This meant that the trust did not consistently protect people from avoidable harm.

Safety and quality of services were a priority for the trust's leadership, and staff at every level in all services, had a focus to improve safety. The trust had a patient safety strategy and had appointed an associate medical director as patient safety lead. The associate medical director had defined his approach to safety in the trust to promoting a culture that was open, supportive, fair and unbiased, and decisive in cases of poor care. The trust had developed a strong safety and reporting culture, and was learning from incidents.

The trust strategy had eight workstreams: to reduce falls, avoidable pressure ulcers, medication errors, healthcare associated infections, to recognise and manage the deteriorating patient, ensure venous thromboprophylaxis and to improve learning from incidents. There was a 'safe care in your hands' campaign to support the strategy, via such initiatives as the roll out of an electronic incident reporting system, safety walkabouts and cultural surveys.

Environment and Equipment

- There were safety concerns about the environment and maintenance. Many areas of the trusts hospital buildings were constructed before new buildings guidance was established, and areas were cramped, such as the general intensive care unit (GICU) and children's wards. Some environments needed improvement change obsolete call bell systems, and prevent power interruptions in the GICU. The trust was also managing resources and having to decide on priorities. The estates department also had vacancies and were under-resourced to manage ongoing maintenance. The trust had a quarterly environmental operational steering group meeting for clinical

staff to raise concerns with the estates management team but some clinical staff identified the need for more effective liaison. Estates maintenance was behind scheduled and areas were being prioritised based on risk; but some areas did not have regular checks. Following our inspection, the estates department had started walkabouts in the GICU to understand issues, plan work and provide advice.

- Most areas were well equipped, but there was a shortage of some basic equipment on the wards, such as pulse oximeters and blood pressure machines, and there were delays in obtaining pressure relieving equipment. Interruptions to the electrical power supply on GICU interfered with lighting and with the continuous functioning of some equipment, such as monitors.
- At the Princess Anne Hospital, not all staff were aware of the location or correct use of equipment for the safe evacuation of a woman who may have collapsed in a birthing pool. One of the operating tables could not be adequately lowered for surgery. Theatre capacity met meet national standards as set out by the Royal College of Obstetricians and Gynaecologists (RCOG) in the mornings. In the afternoons a second theatre was on standby for emergencies only.

Cleanliness, infection control and hygiene

- Hospital environments were visibly clean and the trust had performed above the England average in the patient-led assessments of the care environment (PLACE) for cleanliness (99%, compared to 98% nationally).
- Staff adhered to the 'bare below the elbows' policy in clinical areas, but were not always following infection prevention and control procedures. This was despite the fact that the trust had experienced an outbreak of Norovirus during the inspection. The trust had re-emphasised the need for robust procedures and we had observed improvements.

Assessing responding to risks

- The use of early warning scores to identify when patients might deteriorate was applied across the trust. Many areas were using the score, but this needed to improve in the children and young people's services. Across wards and departments staff needed to ensure referrals to critical care outreach were timely.

Duty of Candour

- The trust's Being Open Policy was developed in February 2014 and advised staff to be open, transparent and candid with

patients when things go wrong. The policy had been adapted in October 2014, to take account of the Duty of Candour (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014), which came into effect in the NHS on 27 November 2014.

- 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 trust executives and senior staff had analysed their position and preparation in response to the new duty, and identified that the principles of candour were generally well embedded in the organisation, but the requirement to evidence and document conversations with families was not. The trust disseminated guidance and held focused sessions with staff in November 2014. A patient information leaflet was being produced, and video training was being developed for staff, to start in 2015. The electronic incident reporting system and safeguarding systems were updated for staff to provide grounds for non-compliance with the Duty of Candour. All divisional governance teams were asked to consider how they would monitor compliance for moderate incidents.
- Senior staff could describe their responsibilities around Duty of Candour, but junior staff were less clear. All staff, however, consistently told us that the trust supported them to be open and transparent about the need to identify mistakes, accept responsibility and apologise. The word 'candour' was used in terms of the safety vocabulary of the trust, but it was an embedded concept. The implantation of the duty within divisions varied. Some areas had already actively promoted staff awareness and understanding, and could demonstrate where the duty had been enacted, others lagged behind. In diagnostic imaging, we identified that patient safety incidents had been discussed with the patient, but there was no further evidence of written correspondence, or of the information or support provided.

Safeguarding

- Safeguarding was overseen by the vulnerable adults support team (VAST). The group monitored risk and incidents relating to vulnerable adults, and identified the learning from local and national serious case reviews. The group oversaw the

implementation of new guidance and policy, and identified service changes to improve the quality of care and safety of vulnerable patients within the trust. The trust for example, were reviewing 'prevent strategies' (prevention of terrorism) and mandatory reporting for female genital mutilation (FGM).

- The trust had policies on safeguarding vulnerable adults and adult protection, dated October 2014, and for child protection and safeguarding dated January 2013. Staff were aware of the relevant policies for safeguarding vulnerable adults and children, and knew how to access them. Staff were aware of the trust's safeguarding leads.
- Safeguarding adults and child protection training was mandatory for all staff. Approximately 75% of staff were up to date with adult safeguarding training; however, only 38% of relevant staff had child protection training in August 2014, and the trust was not meeting its own internal targets. The trust had reassessed staff that required level 3 training, and some departments, such as in theatres and in A&E, were finding it difficult for staff to attend this training. Face-to-face training was the preference, as this was seen as more robust, but the child protection team did not have the resources to deliver bespoke packages of training to departments. E-learning had recently been developed for level 3 training, but figures were still lower than required, as the training would still take six to seven hours to complete.
- Staff could describe situations in which they would raise a safeguarding concern and could describe the action they would take.
- There was a well-established team for child protection, and procedures were embedded and robust. We observed, for example, procedures for child protection, which were well established in the emergency department. Adult safeguarding was less well developed. There was a lead nurse, who was relatively new in post, and who covered the entire trust. A vulnerable adults support team worked in the emergency department, and was funded until March 2015. A business case was being developed to strengthen this team.
- The trust had had a high profile child safeguarding incident last year. The trust had independently reviewed its procedures, and had co-operated with others across health and social care, including the Local Child Safeguarding Board, to review the incident. The safeguarding actions taken were deemed appropriate, but there were areas for improvement. Policies

and procedures had been reviewed and the learning was being cascaded. This included raising the alert and the initial action to take if a child was considered to be missing, as well as new procedures for monitoring children who leave the ward environment.

Incidents

- The trust had a safety culture and had introduced a new electronic reporting system. Staff told us how they were encouraged to report incidents, near misses and errors, and that they received feedback, and learning was shared as a result. Learning was not widely shared across outpatient areas, and issues with staffing levels in the imaging department were impacting on the time staff had to report incidents, and some were not being reported.
- The trust had had 12,224 incidents from April 2013 to May 2014. The majority (96%) of these incidents were low risk or no harm incidents. Moderate incidents accounted for 3% of all incidents, and serious incidents (severe harm or death) 1%. The majority of serious incidents had been for slips, trips or falls, pressure ulcers (grade 3 and 4) and venous thromboembolism. The trust had reported two 'never events' in 2014 in surgery at Southampton General Hospital. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. Both incidents had been investigated through root cause analysis, and the learning implemented.
- The trust's procedures for the categorisation, investigation, reporting and learning lessons from serious incidents resulting in investigation (SIRIs) were robust. Investigations are scoped and terms of reference are signed off by a multi-professional group, and a clinician chairs the SIRI oversight steering group. Membership is widened for the scoping of investigation of never events, and this includes commissioners. A modified SIRI system was operated for falls, pressure ulcers and venous thromboembolism, as these were comparatively 'regular' occurrences and did not require need the same bespoke scoping and terms of reference setting.
- We reviewed three SIRIs and found these to be well structured, with appropriate conclusions and recommendations, with specific responsibilities and timescale for actions identified. There were areas for improvement, however, which including the listing of patient or family concerns in the initial scoping of the investigation, and for actions to exhibit an awareness of

wider learning. For example, an investigation identified the need for staff in the acute medical unit to have dementia awareness training, but there was no recommendation to check the delivery of such training in other areas.

- Over the last 12-18 months the SIRI has been improved, with the introduction of thematic reviews. This had led to further underlying root causes being identified, such as the failure to recognise early enough the deteriorating patient. A number of in-depth reviews in divisions resulted, and further practical improvements introduced, such as in ED a requirement for senior clinical review of chest X-rays prior to discharge, to guard against overlooked aortic aneurysm. This approach has been welcomed by trust staff and has increased incident reporting.
- Incidents were reviewed at monthly care group governance meetings and exceptions were reported to divisional governance boards. There was learning from incidents in all areas, leading to initiatives such as the introduction of the coloured banding used to identify patients at high risk of falls in the emergency department, intentional rounding for pressure ulcers, and improvements in triage for the assessment of pregnant women.
- The trust monitored areas of poor quality or low reporting, and as a result, they had recently worked closely with obstetrics, where incident reporting had been low and was overly defensive. Training was provided, managers were required to take ownership of the quality of incident reports, and a consultant obstetrician was added to the steering group. This had improved the level of incident reporting, and the quality of advice and challenge.
- The Central Alerting System (CAS) is a national web-based system for issuing patient safety alerts and other safety critical guidance to NHS trusts, health authorities and social services for information and/or action. The trust had an effective system to identify, disseminate, implement and monitor national patient safety alerts from the CAS. Importantly, the trust had identified the appropriate persons as a point of contact to disseminate information to junior doctors. We looked at the implementation and monitoring of three alerts issued by the National Patient Safety Agency (NPSA): 1. Checking pregnancy before surgery issued on 28 April 2010; 2. Essential care after an inpatient fall, issued 13 July 2011; and 3. Oxygen safety in hospitals, issued 29 September 2009. The trust had taken action in response and had changed systems and policies.

There was audit and monitoring and further action taken, for example, where changes were not always adhered. There were ongoing actions for checking pregnancy status prior to surgery and for the management of falls.

Staffing

- Nursing staffing levels had been reviewed and assessed across the hospital using the Safer Nursing Care Tool. High levels of vacancies were impacting on consistency of staffing to these levels, and the National Institute for Health and Care Excellence (NICE) safer staffing guidance. This guidance recommended a minimum registered nurse-to-patient ratio of 1:8 during the day. The trust was making every effort to fill vacant shifts but was not consistently achieving planned nursing levels. The fill rate across the trust for registered staff during the day was 82% and 94% at night, and healthcare assistants were being used to cover.
- Staffing levels were reviewed on a shift-by-shift basis and staff moved across wards to try to mitigate risks; however, this led to concerns about lack of continuity and relevant skills to meet the needs of patients of different specialties. This was accentuated by the high number of, particularly medical, outliers across the hospital, due to high demand and insufficient capacity, and also by the acuity and dependency of patients in medicine, which was increasing the need for more staff.
- The trust's current level of nursing vacancies (November 2014) was 12.6%, but was forecast to reduce to 8.6% by March 2015. Recruitment was ongoing within the UK and overseas. Wherever possible, agency staff or bank (overtime) staff were used. There were two areas of vacancy 'hotspots', in medicine for the care of the elderly with a 25% vacancy rate, and in trauma and orthopaedics (T&O) at 23.6%. Specific recruitment plans were in place for these wards.
- Midwifery staff ratio was 1:31 and was below the England recommendation of 1:29. Midwives were being allocated to women to provide one-to-one care, but frequently worked in different areas in order to do so. As a result, midwifery staffing on the ante and postnatal areas was, at times, below the recommended numbers and this had resulted in the care of women in these areas being delayed.
- Medical staffing was at safe levels in most services, and there was an innovative model of 'lead consultant for out-of-hours' (work). The main medical vacancies were in emergency medicine and trauma and orthopaedics, and national recommendations were not met for consultant cover for the

delivery suite in obstetrics. Locum staff were used, wherever possible, to cover shifts, and medical staff did not identify patient safety concerns with staffing in these areas. However, there was not an interventionist in the neuro intensive care unit at night, for patients who need critical care treatment, including respiratory support. There was also insufficient medical cover, particularly at consultant level, for end of life care services across the trust.

- Low staffing levels in diagnostic imaging services, in particular radiographers, was having an impact on safety.
- Staff told us that they were concerned about staffing, but understood that it was a priority for the trust. The staffing levels and skills mix in some areas, particularly in medicine, surgery and maternity and gynaecology, was identified as a risk to patient safety and these were on the risk register.

Are services at this trust 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.

Overall, we rated the effectiveness of the services at the trust as 'good'. For specific information, please refer to the individual reports for Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House.

The team made eight separate judgements about the effectiveness of services. Seven were judged as 'good' and one was judged as 'requires improvement'; the effectiveness of outpatient services was not rated. This meant that patients received effective care and treatment that met their needs. National evidence-based guidelines and best practice were used to guide the treatment of patients, and clinical audit was used to monitor standards of care.

Patients had good pain relief and appropriate nutrition and hydration. Mortality rates were within the expected range. Seven day services were developing, and were in place for emergency care. Staff worked in multidisciplinary teams to co-ordinate care around the patient. Staff reported that they were supported with training and encouraged to develop their skills. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal guidelines.

Evidence-based care and treatment

- Staff used national guidelines, such as those from NICE and the relevant Royal Colleges, to determine care and treatment, and local care pathways. Local care pathways, care bundles and

enhanced recovery pathways were written in line with national guidance and agreed local policies. In most areas there was adherence to guidance and policies, although we identified some variations, such as in the emergency department.
- The trust formally reviewed all NICE guidance to agree its use and to monitor implementation across services.
- The university postgraduate research group displayed information about ongoing trials in services, so that people presenting with specific injuries or conditions of interest to the research team had the facility to be seen and recruited onto new trials by experts within these fields. Research teams implemented research findings and innovations, where appropriate, within their services.
- The trust was adhering to accreditation programmes where these existed.

Patient outcomes

- The trust participated in all national audits that it was eligible for and had a programme of local clinical audit founded on evidence-based practice and local priorities (such as services that were high risk, high cost or high volume). Standards were monitored through clinical audit programmes and improvement to services occurred as a result.
- Patient outcomes, as measured by national audits, were either better than the England average, and or similar; where they were below the England average, they were improving. Each division had a quality dashboard to monitor clinical outcomes.
- Mortality rates in the trust were within the expected range, although these fluctuated based on the rolling 12 month period of indicators. At times, the Hospital Standardised Mortality Rate (HSMR) was higher than expected and mortality rates were being closely monitored. There were quarterly reports from the medical director on all indicators and mortality outliers. Each speciality held mortality and morbidity meetings to review standards of care. There were specific projects to review standards of care for outlier diagnostic groups.
- A new initiative of Interim Medical Examiner Group (IMEG) meetings had been introduced to rapidly review all deaths in the trust. The group included representation from bereavement care, pathology, the patient safety team, patient support services and senior clinicians. It was led by the associate medical director for safety. This had improved the quality of information on death certificates and the speed of death

certification, information to the Coroner, the communication with families regarding concerns, and the recognition and improvement of patient safety issues, as well as the need to raise awareness about reporting incidents.

Multidisciplinary working

- There was good multidisciplinary team working. Ward rounds were conducted by multidisciplinary teams and staff liaised effectively on the wards to co-ordinate patient care. Patients had been referred to specialists when required, such as for speech and language therapy, dietetic advice, or to the dementia care nurse.
- There were examples of multidisciplinary clinics and services, such as the clinic for children with neuro-muscular conditions, and intensive care services co-ordinated input from pharmacists, dieticians, speech and language therapists, and other specialist consultants and doctors, as required.
- Services were also co-ordinated outside the trust. A good example of this was care of the elderly consultants, who worked on a locality based model and there were named consultants for patients belonging to each GP locality. This had helped in improving continuity of inpatient care, and communication with patients and families, and with other healthcare services in the community. Patients found it beneficial, as they saw the same consultant every time and found it was easier to approach consultants should they need any advice.
- Staff could access mental health assessment, clinical psychology and learning disability support for patients through the partnership that existed with the local mental health trust. Staff told us that mental health services responded promptly to referrals in response to patients in crisis situations.
- The trust was meeting national standards where multidisciplinary working was promoted; for example, for stroke patients to be cared for on a multidisciplinary stroke ward, and for cancer patients to have decisions for their care and treatment co-ordinated by a multidisciplinary team.

Consent, Mental Capacity Act & Deprivation of Liberty Safeguards

- The trust had a consent policy, which included details about what to do when patients lacked capacity and where to obtain more specialist information.
- The hospital had four different types of consent form in use, including one for children. The hospital undertook an annual audit of consent; the last audit was in December 2013. This demonstrated improvements in many areas, but pregnancy

status for females prior to procedures, and confirmation of consent when the operation date was over four weeks, both required improvement. Actions were planned in response to these issues. During the inspection, we found consent forms had been completed appropriately and included details about the procedure/operation, and any possible risks or side effects were completed.

- The majority of medical and nursing staff demonstrated an awareness of their responsibilities under the Mental Capacity Act 2005, although many requested further training. Some staff were not clear about Deprivation of Liberty Safeguards (DoLS), particularly in the emergency department and in elderly care medicine. The trust had a comprehensive Mental Capacity Act and DoLS assessment algorithm dated November 2014. There was also a DoLS assessment proforma, and this included referral procedure details for different age groups, and for working hours and 'out of hours'.

Are services at this trust caring?

Good

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

Overall, we rated the care provided by staff at the trust as 'good'. For specific information, please refer to the individual reports for Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House.

The team made nine separate judgements about the caring. Eight were judged as 'good', and one in children and young people's services, was judged as 'outstanding'.

Patients received care that was delivered with compassion and kindness, and were treated with dignity and respect. Patients and their families told us they were involved in their care and treatment, and that this met their needs. Patients, and their families, told us of good communication and emotional support from staff.

Compassionate care

- Patients, their relatives and friends told us they were treated with kindness and compassion, and with dignity and respect by staff in the trust. We observed staff, throughout the trust, demonstrating the values of compassion care. Staff introduced themselves to patients and addressed patients by their preferred name. Staff were responsive to patient needs and answered call bells promptly. Staff in the outpatient departments were approachable, professional and friendly, putting patients at their ease.

- In the emergency department, we observed the receptionists demonstrating outstanding social interactions. The receptionists, although busy, made considerable efforts to reassure, inform and direct people presenting to them. This practice was evident on each shift, including the night shift. This should specifically be seen in the context of an exceptionally busy department, working under extraordinary pressure because of the Norovirus in the trust and the national capacity pressures on the NHS at that time. Staff in the emergency department were responsive to patient's needs, and provided reassurance and explanations that were delivered sensitively to patients about their care. Many patients in the department waited on trolleys whilst waiting for an inpatient bed and staff ensured their privacy and dignity were maintained by providing care in another room specially set aside for care and treatment, when necessary.
- Children, young people, their parents and families praised the compassionate care and the friendly, caring and supportive atmosphere generated by staff. There were compliments in the form of 'thank you' cards on wards and these included comments of thanks and gratitude for the time and commitment to providing a compassionate caring experience.
- The trust had a better than the England average response rate for the NHS Friends and Family Test and scores, overall, were above average for inpatient wards and in the emergency department. The trust was similar to other trusts in the CQC inpatient survey 2013.
- The CQC Survey of Women's Experiences of Maternity Services 2013, and also responses to the Friends and Family Tests, showed the trust to be performing about the same as other trusts in maternity care.
- For the cancer patient experience survey (2013/14), the trust was similar to other trusts overall.
- The trust breached the mixed sex accommodation rules, at times, and we observed this on the acute medical admissions unit and in the cardiac short stay unit. This compromised patients' privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients and their relatives told us they were involved in decisions about their care and treatment. They told us their care and treatment options had been explained to them at all times and they had sufficient opportunity to speak with consultant staff.

- In the emergency department, medical staff were praised for the quality of their communications to the families, ensuring that they understood the sequence of events, and the likely timings around them. Relatives understood why a patient had to be on trolley, but praised nursing staff and healthcare assistants for the checks done on patients.
- In critical care, relatives told us they felt fully informed about their family member's treatment and care. Staff communicated sensitively, and explanations about the equipment and what was happening had reduced any anxiety. Nursing staff kept diaries by the patient's bedside outlining events to help fill in gaps for patients who might have been unconscious during their stay in the critical care units. Consultants in cardiac intensive care arranged weekend meetings with bereaved families to discuss their relative's treatment and death, in order for them to better understand the patient's journey and the reason why they did not survive.
- In children and young people's services, staff spent time talking to parents, and also to the children and young adults, so that they could all understand, in way that was meaningful and reassuring to them, what was happening during their stay. Play leaders spent time with children to support them to understand, and for them to become familiar with their environment.
- The families of patients receiving end of life care told us they were informed about the condition of their relative. They told us they had time to speak with doctors and they did not feel rushed; their questions were answered in a detailed manner. They found the information helpful and it reassured them that their loved ones would be supported in their remaining days. 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 care patients. Mouth care kits were available on wards and were placed at the bedside.

Emotional support

- Staff across the trust spoke very positively about the chaplaincy and bereavement teams. The services these teams provided were highly valued by staff, patients and their families. A multi-faith chapel was available for people of all faiths to support their spiritual needs and there were arrangements for volunteers of different faiths to help people who had spiritual needs.
- Staff demonstrated a good awareness of patients emotional support needs, conversations were held in private places, and

actions were taken to support the relatives of patients. We observed many episodes of kindness from motivated staff, towards patients and their relatives. For example, nursing staff had arranged for a private ambulance to take a patient on the respiratory ward to meet her husband, who was terminally ill in a nearby hospice.

- Psychological support was available, although this was not consistent across the trust. The chaplaincy offered this support, for example, in the emergency department. Stroke patients had a mood assessment and had appropriate clinical psychological referral. Psychology support was available for young people on the oncology unit, and when a young person died, psychological support was available for their relatives. The general intensive care unit included psychological support in their follow-up clinics, but this was not funded, and the clinics were run voluntarily by consultant staff. The neuro intensive care unit used patient profiles, so that they could talk to patients about topics that interested them whilst they were unconscious. Specialist nurses followed up patients after discharge, for care and emotional support, and in cardiac intensive care relatives of patients who had died were invited back to discuss their care and treatment, but emotional support was also provided.
- In the children's and young people's services, play leaders and youth support workers in the oncology unit provided advocacy and emotional support for children. Peer support and social events were actively promoted with parents and children in the neonatal intensive care unit and the oncology unit. Parents and carers could accompany children to the anaesthetic room and stay with them until they were asleep, and were with their child in theatre recovery when they were awake. Families were able to stay close to their children by their bedside during their hospital stay.
- Women told us they felt able to cope if outcomes were different to what they had expected; for example, there was midwife support if a women was transferred to hospital from home or from the New Forest Birthing Centre; end of life was recognised and there was good palliative care support. The maternity service employed a bereavement specialist midwife and a perinatal mental health midwife. Gynaecology services had a link nurse for palliative care.
- The trust Interim Medical Examiners Group had improved the emotional support to relatives following the death of a patient.

Summary of findings

In the review of the patients death, relatives were provided with accurate advice and information in a supportive way that helped to address any concerns they may have had about care and treatment.

Are services at this trust responsive?

Requires improvement

Overall, we rated the responsiveness of the services at the trust as 'requires improvement'. For specific information, please refer to the individual reports for Southampton General Hospital, the Princess Anne Hospital and Countess Mountbatten House.

The team made nine separate judgements on whether services were responsive. Four were judged as 'good' and five as 'requires improvement'. This meant that the trust was delivering responsive services, but not consistently, and there were areas where standards were not met.

The trust was planning and delivering services in response to local needs, and was working with partners and commissioners to anticipate and respond to the increasing demand for services. Strategic plans were being generated and considered, but this work was often reactive because of the pressures on services, particularly from the emergency care pathway. The premises and facilities of the hospitals required improvement and refurbishment in many areas, to deliver more effective services and a better patient experience. There was good support for people with a learning disability, and for people living with dementia, which was developing across the trust. Where it happened, the support was excellent and the care passport scheme and dementia care bundle were examples of this. Patients were aware of how to make a complaint and complaints were handled appropriately. However, complaint responses could take time to complete and referrals to the ombudsman were increasing because of incomplete or unsatisfactory responses to patient concerns.

Service planning and delivery to meet the needs of local people

- The trust used information to understand the needs of the population it served, and services were changing in response to increasing demand. Pressures on the emergency care pathway had prompted many service changes; for example, a new model of care called the 'Pit stop' was introduced in the emergency department to improve safety with large numbers of emergency admissions; ambulatory care had also developed, as had community respiratory services in medicine to avoid patient admissions. Work with commissioners and

partners was leading to the extension of services, such as mental health liaison services, specialist nurses for end of life care at the weekend and evenings, and weekend outpatient clinics. There were considerations around developing integrated pathways of care, but these were under-developed.

- The trust understood the needs of the local population and was planning for service change, but many changes were made in reaction to constant service pressures and could be rushed even when planned, such as the opening of critical care beds when appropriate staffing arrangements had not been completed. Important and necessary strategic changes were being delayed, such as the new Children's Hospital emergency department, because resources were diverted to the emergency care pathway and other priority areas of the trust.
- The environment and facilities within the trust required improvement, and these were impacting on patient safety and the patient's experience of care. This was evident, for example, in terms of critical care, children's and young people's services, and on the trauma and orthopaedic wards. The trust was having to make key decisions, on competing priorities, with limited resources. The question of what needed to be fixed first was being openly debated, and risks were being managed, but staff were working in many areas that were below standard.

Meeting people's individual needs

- The trust had a learning disability policy and an action plan for 2014/15, where they had identified actions for staff training and communication, specialist advice, increased partnership, and to develop a better nutrition assessment tool and flagging system for people with a learning disability. Staff had a good level of understanding about the care of people with a learning disability, although this varied across the trust. There was a specialist learning disability nurse and good use of the care passport scheme (a document used by patients with a learning disability, to outline their care needs and preferences, and provide information about them for staff to reference). We observed that reasonable adjustments were being made; for example, play leaders in children' services used pictures and signs, and one leader spoke Makaton, a language programme which uses signs and symbols; patients had longer surgical times to reduce anxiety; and outpatients had appointments early to reduce waiting times. Changes to the IT system, to flag up patients who were admitted to the hospital, were delayed however, because of resource issues.
- The dementia care strategy aimed to develop a dementia-friendly environment within the trust. The trust had an Admiral

clinical nurse specialist, trained in the support of patients living with dementia and their families. Many staff had completed basic dementia training, and in all areas, staff demonstrated a good understanding of the needs of people living with dementia. The trust had adopted policies and procedures designed to identify and promote the support of people living with dementia. For example, all patients over 75 years were screened on admission for dementia using recognised methodology. The trust used a 'dragonfly' symbol to identify people on the elderly care and medical wards; an orange card was included in the patients records for outpatients. Reasonable adjustments were being made to support patients and reduce their stress and anxiety, and relatives were allowed to stay close by patients during their stay.

- The trust was piloting its dementia care policies on the older people's ward, with the aim to roll out care standards across the trust. The trust had introduced the 'This is me' booklet for patients living with dementia. This was a booklet developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of patients. These were completed appropriately on the elderly care wards. The Admiral clinical nurse specialist visited all the care of the elderly wards and also saw referrals on the other medical wards. Wards had a named dementia champion. The trust had developed a 'dementia care bundle' which assisted staff to meet the needs of patients. Dementia-friendly designs were incorporated into the care of the elderly ward areas; for example, a colour-coding system was used for different bays, and pictorial signage was also being used.
- A care package had been developed for patients in intensive care areas, who exhibited challenging behaviours as a result of their condition or illness, to help staff to support these patients and meet their individual needs.
- Facilities for children were a concern. The children's wards did not support disabled access to bathroom, shower and toilet facilities. Some environments required refurbishment and did not support a good patient experience. There was a dedicated teenage and young adult oncology unit, and this had been designed and built to meet the needs of this age group. Young people did not have facilities on other wards, and were often in areas with children much younger than themselves.
- The services took account of people's cultural, spiritual or religious needs. There was a multi-faith chaplaincy and

volunteers of different faiths to support patients. A special room was available for families to use for prayer, and specific religious and cultural practices were followed for patients who had died.

- There was an arrangement with the local NHS mental health trust to provide a liaison service for people with learning disabilities and mental health disorders. People attending with mental health problems had a comprehensive assessment, which included a suicide risk screening and a capacity assessment. The mental health team worked in the emergency department and inpatient areas. The trust had identified risks in the assessment of patients and the management of complex psychiatric illnesses, and there had been joint working with the mental health trust to strengthen the services. Carers of patients with mental health conditions could also stay close during their stay, and could stay overnight if that was beneficial to the patient and deemed appropriate. Children had direct support from a mental health nurse and a clinical psychologist employed by the trust.
- Information leaflets were available, but the majority were in English. Interpretation services were available and staff knew how to access the service when needed. Patients were supported by relatives, where appropriate.

Access and flow

- Bed occupancy at the trust was 92% (January 2013-March 2014), consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. The trust had been operating at near 100% occupancy in the months leading up to and during the inspection. Adult critical care was at 89.36% bed occupancy – above the England average of 83.24%. In the months leading up to and during the inspection, bed occupancy in the units was running at between 90% and 100%.
- There were significant and enduring pressures on the emergency care pathway and the impact of this was being felt throughout the trust. The majority of patients were assessed and treated within standard times in the emergency department, but the trust was not meeting the emergency access target for patients to be admitted, transferred or discharged within four hours. Patient flow throughout the trust was a significant concern, and patients had lengthy waits for an

inpatient bed and, at times of peak demand, many waited on a trolley in the corridor. The emergency department accurately prioritised patients for beds based on clinical needs and not on time of attendance.

- Many inpatients, particularly medical patients, were not on specialists wards. On one day during our inspection, there were 55 medical outliers (patients placed on a wards other than that required for their medical condition). Patients were reviewed appropriately by medical staff, but some nursing staff told us they did not always have the appropriate skills to care for patients.
- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged, but are unable to leave the hospital due to external factors. During our inspection, 200 (16%) medical patients and 54 (6%) surgical patients had a delayed discharge. The main cause of delay was the provision of community services, especially care home places, to meet patients' ongoing needs. On the care of the elderly wards, the social care assessments were not done until a patient was medically fit for discharge; planning did not start while the patient had ongoing care, and there were delays to assessment. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and on the service overall. However, the trust was not meeting its own internal targets to review and discharge patients, who were medically fit and could go home, at set times during the day. Patients were positive about the discharge lounge and this was working well, but it was only used for medical patients.
- The trust had a steering group to improve discharge arrangements and this had senior management and clinical support and leadership. This included plans to commence discharge on admission, and for patients to have an estimated date of discharge and best interest assessment within 48 hours. Patients would be allocated for fast track, simple or complex discharge as soon as possible, and assessment and management would be supported by the trust's integrated discharge bureau working in partnership with commissioners, the local authorities, and the local community and mental health trusts.
- The trust was meeting the national target for 92% of patients to be waiting 18 weeks or less from referral to treatment (incomplete pathway). There was, however, a backlog of patients waiting for surgery, and the trust was not meeting the

national target for 90% of patients to actually be treated within 18 weeks (admitted pathway). The trust could demonstrate that it was focusing on the longest waiting patients, and those with complex and urgent cases for surgery. Performance against this target was improving; for example, increased theatre use had improved waiting lists in trauma and orthopaedics. However, emergency admissions impacted on capacity and were adding to pressures on services. The lack of available beds was resulting in cancelled operations and patients spending longer times in the theatre recovery areas while they were waiting for a bed. The trust had improved performance over the year on reducing cancelled operations, and for patients with cancelled operations being treated within 28 days, but it was still not meeting national targets.

- The trust was not meeting the national referral to treatment target time for 95% of patients to be referred and treated within 18 weeks for outpatient services. In some outpatient services, clinic hours were being extended to evenings and also run on a Saturday to improve access. Waiting times for patients upon arrival in the outpatient clinics varied. Some patients could wait several hours to be seen in some clinics, and were warned in advance of this possibility.
- Over 2013/14, the trust had not met the two week cancer waiting time targets from referral from a GP to being seen by a specialist. During September to December 2014, the trust met this target. The trust also met the target for people waiting less than 31 days from diagnosis to first definitive treatment, although this was below the national average. The trust was not meeting the target for people to be waiting less than 62 days from referral to start of treatment. There was a detailed cancer recovery plan, which included seeking specialist external advice from the NHS Interim Management and Support Team.
- There were a higher number of patients discharged and admitted overnight than in similar units. The Core Standards for Intensive Care 2013 detail that historically, discharges from critical care services overnight have been associated with excess mortality. However, regular out-of-hours discharges to the general wards occurred. There were a higher number of discharges delayed over four hours compared to similar units; although patients were well cared for, they were medically fit for discharge and the unit was not the appropriate setting.
- Staff were working to improve access to children's services; for example, there were extended clinics in the orthopaedic physiotherapy service and the back pain clinic, and changes were planned for the day care unit. However, there were only a

limited number of pre-admission and assessment clinics taking place to prepare children in advance, and to ensure that the required information was readily available and used for assessment. There could be waiting times of up to a week for the rapid access fracture clinic, and children often stayed in the paediatric admissions unit for more than the expected 24 hours, because inpatient beds were not available.

Learning from complaints and concerns

- During 2013/14 the trust handled a total of 582 complaints. The top three themes were inappropriate medical treatment (120); communication/information (88); and outpatient delay/ cancellation (60). Over the last three years the overall volume of enquiries, concerns and complaints had increased by 36%. Of these, the volume of complaints had reduced by 14%.
- During 2013/14, the Parliamentary and Health Service Ombudsman (PHSO) had 60 complaint contacts from the trust. Seventeen of these were accepted for investigation and four were upheld/partially upheld (0.7% of all complaints). The trust figures were similar to other trusts of a similar size. However, during 1 April to 30 November 2014, the trust saw an increase in the number of complaints upheld or partially upheld by the PHSO. The trust received 297 complaints; nine of these were accepted for investigation, of which five were upheld or partially upheld (1.7% of all complaints). The PHSO had identified key recommendations for clinical practice, but also the need for the trust to consider evidence more robustly, rather than taking statements at face value. The Trust had taken these recommendations on board and an improved position was emerging for Q3 and Q4, with only 3 complaints upheld or partially upheld
- The trust had an internal audit review of complaints in March 2014. There were several recommendations:

- to improve documentation
- have an identified response timeframe
- ensure complaints were handled in line with national recommendations; and
- improve the actions taken and learning outcomes in response to complaints.
- The trust had an improvement plan and key priorities during 2014/15 were focused around
- listening; supporting and improving access to the complaint process;
- complaint handling and staff engagement;
- and organisational learning and reporting.

Summary of findings

- The complaint's policy was agreed in October 2014. The director of nursing was the lead for complaints and there was a non-executive lead and a medical lead. The patient support services were the team responsible for managing complaints in the trust.
- There had been some significant changes this year, for example, a patient 'Have your say' leaflet developed with Healthwatch, and a complaint assessment process (which identifies the severity of the complaint, and the level of investigation, action, quality assurance and organisational learning that will be required) A systematic learning process had recently been introduced and key performance indicators for complaints. The chief executive also scrutinised and commented on all complaints. Further actions were identified to improve communication with patients and develop other opportunities for feedback. For example, to review and learn from dissatisfied complainants; have a lead independent investigator; and to improve staff training.
- Complaints were investigated within care groups, and there were monthly reports to divisions, and quarterly reports to the trust patient experience group. The annual complaints report was relayed to the board. Monitoring information included information on themes, the timeliness of actions taken, and lessons learnt. There were action plans to demonstrate action taken in response to complaints and the PHSO reports; however, there was no evidence that these actions were monitored and embedded.
- The trust did not have an overall timeframe in which to respond to complaints, and to ensure consistent and prompt responses. The trust used a complaint assessment process which identifies the typical response timeframe based on the severity of the complaint. From 1 April to 30 November 2014, approximately 94% of complaints were acknowledged within three working days, and 96% were closed within the expected timeframe. However, the average time to close a complaint was 42 days, and the range was two days to 172 days. Some 31% of enquiries or concerns raised by patients were resolved within the target of 'the end of the next working day'.
- We reviewed three recent complaints and one complaint that was ongoing. The recent complaints were responded to according to guidelines, although the responses to the primary complaint did not always provide adequate detail or clarity on the lessons learnt. The ongoing complaint had not been concluded from December 2013 and had not had a recent review. The complainants did not have final outcomes or information on when the complaint would be resolved. The

findings of the complaint had, however, been implemented. The trust had only started to monitor and report on open and overdue cases in November 2014. This oversight had been escalated to the care group management team. .

- Patients and their relatives were made aware of how to complain through the 'Have your say' leaflets. These were on display and available throughout the trust, although this was not apparent in the emergency department. The trust had plans to make the patient support services team more prominent, and located at the front entrance to Southampton General Hospital when this was refurbished.
- Staff were aware of the trusts complaints policy, and complaints were handled in line with this policy. There was evidence in all areas, of learning and improvements to services as a result of complaints. The chief executive reviewed all complaints to ensure the tone and appropriateness of the response. It was felt that the quality of responses to complaints had improved because of this extra step.
- The trust had undertaken a complaints satisfaction survey to identify people's experiences of the process. The results were still being analysed at the time of our inspection. There had not been an audit of complaint responses to ensure that the narrative met with national guidelines.

Are services at this trust well-led?

Good

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

We rated well-led as 'good'.

The trust had a vision and clinical strategy for 2020 that had been written eight years ago. This was being refreshed to take account of its key tenets, and to provide a more up-to-date strategic vision on excellence in healthcare, working in partnership and supporting innovation. Current strategies and plans were dealing with the immediacy of the increasing demand for services, and balancing quality, targets and finance was a serious challenge. The trust was having to take difficult decisions on long-term goals to ensure sustainable services.

Governance arrangements were well developed at trust, division, care group and ward level. The trust had a comprehensive integrated performance report to benchmark quality, operational and financial information. Clinical quality dashboards were being developed from board to ward, to improve the quality of

information, monitoring and reporting. Risks were appropriately managed and escalated to the board overall, although this did not happen in a few areas, and the actions taken on some risk were not always timely. Safety information was displayed in ward and clinic areas for patients and the public to see.

The leadership team showed commitment, enthusiasm and passion to develop and continuously improve services. The trust identified a challenging patient improvement framework, and could demonstrate some improvements, if not achievement, in many areas.

Staff at every level, told us about the visible and inspirational leadership of the chief executive. Staff were positive about working for the trust and the quality of care they provided. The trust was in the top 20% of trusts for staff engagement. There was a focus on improving patient experience, and public engagement was developing to ensure the public had jargon free communication; there was consultation on services, and patients would be told how their feedback was used to improve services.

The trust had a culture of innovation and research, and staff were encouraged to participate. There were examples of research that were nationally and internationally recognised. Staff were supported to lead innovation projects in their work environment.

Cost improvement programmes were identified, but savings were not being delivered as planned. The trust was taking further action to reduce the risks of financial deficit but maintain quality.

Vision and strategy

- The trust had a far-reaching corporate 2020 strategy. The strategy had been written in 2007, and identified the direction and positioning that the trust would take in the health and social care system by the year 2020. The trust was 'to be a world-class centre of clinical and academic achievement, where staff work to ensure patients receive the highest standards of care and the best people want to come to learn, work and research'.
- The 2020 strategy defined having nationally recognised specialities and local high quality services.The aim was to develop compassionate services, listen to staff, and be open and transparent; and there were six enabling strategies; these focused on improving:
- Clinical services
- Patient experience
- Staff experience
- Citizens experience

- Education and training
- Research and development.
- The strategy was over eight years old; elements were understandably dated and the healthcare arena had changed. There was some focus on working with partners to improve the efficiency and effectiveness of services, but not to the defined models of integrated healthcare services and pathways of care that are seen as necessary today. The trust was currently refreshing this strategy to have a more up-to-date focus on its current environment and plans for the trust. The refresh was being discussed by the board during our inspection.
- The trust operation and strategic plan for 2014-16 identified a continued focus and investment on quality and safety, to deliver national performance targets and enhance patient experience, as well as responding to greater local health demand, developing and working with partners, so that people get care in the right place, at the right time, and which may not be in hospital.
- The trust's objectives had remained the same; that is to be trusted on quality by staff, patients and the public; to provide the services that commissioners and the taxpayer can understand and afford; and to provide excellence in healthcare, developing better treatment for patients, and training healthcare professionals for the future.
- Service strategies were focused on developing capacity to respond to local needs, and there were projects which demonstrated 'fresh thinking'. There was less focus on integrated models of care, and operational planning timescales were being foreshortened in the face of increasing pressures on services.

Governance, risk management and quality measurement

- The trust quality governance structure was managed through the quality governance steering group, which reported to the trust executive committee, and then to the board. The trust quality governance strategy (2014-17) had four core elements: regulation, compliance and assurance; patient safety; patient experience; and clinical outcomes and effectiveness (which included operational performance). Each of these individual strategies identified cultures that should be promoted across the trust; in common was the need for 'openness', 'learning' and a 'patient focus'. There were sub-committees and groups to manage specific areas of governance, such as medicines

management, safeguarding, or serious incidents requiring investigation. The quality governance strategy was underpinned by work activity and outcomes described in the Patient Improvement Framework (PIF) 2014/15.

- The trust used internal quality indicators, mandated quality performance metrics, and external reports, such as Hard Truths, the government response to the Francis Inquiry, and the Keogh Review, to develop their PIF; for example, to reduce pressure ulcers, improve referral to treatment times, or achieve national outcomes for stroke care. The framework included areas of innovation, such as for every speciality to develop a key clinical outcome measure. The framework was seen as challenging, but the trust could demonstrate some improvements, if not achievement, in many areas.
- Governance arrangements were devolved into the trust's four divisions (A,B, C and D) and these arrangements were robust. The divisions consisted of care groups for specific speciality areas, such as emergency medicine, surgery, and child health. Each division had a governance manager responsible for the co-ordination of the governance agenda. Care groups held monthly multidisciplinary governance meetings to review quality, risks and operational performance. These groups reported monthly to divisional boards, which in turn produced monthly exception reports to the trust's executive committee. The trust's executive committee and the board reviewed the patient improvement framework quarterly.
- The integrated performance report included data on performance and capacity, safety, clinical outcomes, patient experience, finance, staffing and research, and education and development. Much of the trust information that was available was collated at a trust-wide level. There were divisional, care group and ward clinical dashboards. These held information on a narrower set of metrics, covering patient safety, patient experience, operational issues and workforce. These dashboards were at an interim stage of development; for example, not all wards were included, and it was difficult to get care group or ward based figures, such as on clinical outcomes, avoidable harms or training.
- Divisional risk registers identified the risks and concerns of staff, and these were appropriately escalated to the corporate risk register. Mitigating actions and controls were detailed in many areas, but these were not always clearly defined; for example, some environmental risks were waiting for estate or business

reports, and some action timescales had passed. There were a few areas where risks, identified by staff, were not appropriately escalated to the boards, such as those in critical care, theatres and radiology.

- The corporate risk register included clinical, organisational and financial risks, and used likelihood and severity criteria for risks to develop a ratings score. The board assurance framework was extracted from the corporate risk register (and viewed by board as a separate document) and used to identify and provide assurance on high level strategic and operational risks. Board papers also identify 'horizon scanning' risks although the processes to identify anticipated and potential high level strategic and operational risks needed to be clearer. There was not an integrated approach to internal and clinical audit, or clear accountabilities framework for the key governance roles from ward to Board, which would help to underpin this.
- The trust board annual business planning cycle (2014-15) identified that the integrated performance report was monitored monthly, and progress against the trust's strategy and annual plan quarterly. The planning cycle did not detail how often the board assurance framework was monitored.
- The trust had undertaken four internal quality reviews: in trauma and orthopaedic, surgery and cancer care, general medicine and child health, and intended to extend these to other services. The methodology was based on the Keogh mortality reviews and the Care Quality Commission inspection methodology. The teams included staff, commissioners, GP leads and trainees from medicine and nursing. The reviews were led by the medical director and director of nursing, and identified areas for improvement (on which action was being taken) as positive findings in services.

Leadership of the trust

- There had been some significant changes to the trust board leadership team over the last 18 months. Many directors had been in post for a number of years. The chief executive officer (CEO) was relatively new and had started in post in June 2013. The CEO, under a review of executive portfolios, had increased the number from six to seven by splitting the role of chief operating officer (COO), to create an internally-focused COO and an external-facing director of transformation and improvement. The previous chief operating officer was appointed as the director of transformation and improvement

in January 2014. The chief operating officer was appointed in December 2014, but had had the interim post for several months. There were two new non-executive directors who had been appointed in 2014.

- The non-executive directors had a broad range of experience, and appeared strong and effective as a group. They demonstrated an understanding of, and commitment to, the safety and quality agenda, and were definitive about the high level of challenge they were required make and the response they would always expect from the trust. The board worked well with governors, and had improved their induction and training, and liaison with NEDs and with the CEO.
- The leadership team showed commitment, enthusiasm and passion to develop services for patients. They were rising to the challenge of continuous quality improvement alongside a rising demand for services and increasing financial constraints. The executive and non-executive directors told us they were supported to develop their roles and this included board study sessions, and after a number of 'false starts', a board leadership and development programme had been agreed.
- The workings of the board had been reviewed by external consultants in October 2013, and a follow-up report was produced in June 2014. This identified that the board worked effectively, although the quality of reports and information to the board needed to improve.
- Executive portfolios overlapped in places, but the executive team communicated well and independence prevailed where it was important; for example, performance monitoring and delivery were separated. There was positive feedback from staff about the changes, although some confusion remained between the medical director and chief operating officer posts. There was feedback that as both of these positions were held by doctors, the responsibilities with divisional leads, job plans and roles were being confused.
- The leadership team were clear about the strategic direction of the trust, and this resonated through the organisation. Staff were aware of the reasons for change, but there were a few areas of tension between senior managers and clinicians, such as in critical care, diagnostic imaging and the community hospice team.
- The NHS Staff Survey 2013 identified that the trust was similar to other trusts for the percentage of staff reporting good communication between senior management and staff. Staff were overwhelmingly positive about the visibility and inspirational leadership and support of the CEO. They pointed

to significant change in the focus on patients and quality since her appointment. In the NHS Staff Survey 2014, the trust improved on this indicator, and was now in the top 20% of trusts for communication.

- Clinical leaders were being developed through leadership programmes. The trust's Leadership Academy was a pipeline for senior clinical and non-clinical leaders to develop their leadership skills and to support the implementation of their ideas in the workplace. The trust also identified clinicians for projects and committee roles that developed their areas of interest and would be of significant benefit to the trust. There were doctors, for example, leading in areas of information technology, clinical law discharge planning.

Culture within the trust

- The values of the trust are described as 'Patient's first, working together, and fresh thinking'. All staff in all areas were aware of the values of the trust, and many staff verbalised and demonstrated their passion, and were committed to ensuring the quality of the service they provide. There was a palpable feeling of a strong patient focus and collective responsibility for quality. There was an openness and transparency about when things go wrong, and staff were supported to report incidents, and to discuss openly what they did not know.

- The trust was driven to meet performance targets and had financial constraints, but quality was seen as the priority. There was cohesion between the trust leadership and staff. The NHS Interim Management and Support Team had expressed a concern in 2013 that there were indicators that waiting lists were being 'managed', and patients were being admitted for surgery before 18 weeks, rather than those that were waiting the longest, or with complex and urgent needs. The data in 2014/15 indicated the reverse, and patients were being admitted based on clinical needs. The CEO described meetings with surgeons where patient lists were discussed in detail to ensure that those in most clinical need were operated on; the emergency department also focused on clinical need when deciding on which patients were being admitted to inpatient beds.
- The trust's divisions had once been separately managed units, and the care groups within divisions were based on management spans of responsibility rather than on care pathways. However, staff told us there was a better focus on the divisions working together to respond to the increasing demands on services and on the trust. Operationally, there

were still gaps in joined-up working, such as in the referral across specialities, and the recognition of the impact of emergency admissions that created pressures points in critical care and theatres. It was recognised that the hospital was running 'hot' and this was expected to provide value for money; but some services were at critical points of resilience, and pathways of care through the hospital needed better definition.

- The trust was undertaking a cultural safety survey but this was still under development. A patient safety had been undertaken in theatre which had demonstrated improvement in staff raising concerns, being supported and promoting patient safety.
- The trust had requested an external review of equality and diversity. The review specifically included its employee relations with Black and minority ethnic (BME) staff, and its approach to managing complaints from BME groups. The review reported to the board in November 2014. BME staff formed 22% of the trust's staff, although representation at executive level was 0%, and NEDs 6.7%. The report found evidence that BME staff felt discriminated against when it came to disciplinary action, promotion, recruitment and training. BME staff were significantly over-represented in performance, conduct or dismissal cases, and where allegations were unsubstantiated; these had not been investigated to understand the issues. Some staff felt unsupported in many areas by managers within the trust. Where BME staff were subject to complaints from patients and relatives, for example, about accents or communication style, they felt unsupported by managers. There was confidence in the changes to the culture with the arrival of the CEO. The report made several recommendations to integrate an equality and diversity culture and strategy within the trust; from organisational development to the patient improvement framework to clinical strategies. The trust was actively involved in resolving these issues. The trust had developed an action plan in response, and for example, where allegations were unsubstantiated, some had been investigated. Staff leads for the Ethnicity Inclusive Network were confident that these actions would be supported. They identified the positive leadership and momentum that the CEO and the director of nursing and organisational development had provided.
- Feedback from commissioners, stakeholders and the local Healthwatch groups was that the trust was open and transparent, and the leadership was working well with its partners. Historically, the trust was seen as a 'big player' leading on local decisions; however, leadership changes were seen as positive and were promoting effective partnership working. The

trust actively encourages appropriate external representation on its key quality committees, both from representatives of patients and from other providers, commissioners and stakeholders.

Fit and Proper Persons Requirement

- The trust was prepared and was implementing its plan to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014), which ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust policy on pre-employment checks (2011) covered criminal record, financial background, identity, right to work, employment history, professional registration and qualification checks. It was already part of the trust's approach to conduct a check with any and all relevant professional bodies (for example, medical, financial and legal) and undertake due diligence checks for senior appointments. This, for example, would exclude candidates who could not demonstrate they were capable. The trust was introducing additional checks for non-executive directors (NEDs) to ensure references were obtained from substantive employees, and routine checks on the Companies House website to identify any disbarment from funding a business.
- The board agreed the FPPR for executive directors and NEDs in November 2014. They also decided to widen the spectrum of posts required by the regulation to include the Trust Executive Committee and other relevant senior appointments. The board agreed, and signed off the action plan to:

- Review the pre-employment policy to ensure they meet the requirements of the Regulation.
- Issue new contracts for all directors to formally apply the requirement to their terms and conditions.
- Conduct appropriate retrospective checks for all current board members.
- Amend the appraisal system to include the FPPR.
- Amend the directors' Code of Conduct to include FPPR.
- Add to the annual update to the declarations of interests of board members, a declaration that they remain fit and proper persons.

- We reviewed the personnel files of three directors on the board. One was appointed since the Regulation came into force, and two were appointed prior. The trust informed us that they had

proceeded as if the requirement was in place. The files provided evidence that relevant checks had been done. Only one file (prior to the regulation) would have required a more appropriate referee.

- The trust had also determined that they did not require a disclosure and barring service (DBS) check for all NEDs, and they only had these checks for three out of the eight NEDs. Without a DBS check, the trust will not fully comply with Schedule 4 part 2 of the Regulation, to ensure appointees are of good character. The trust was now reviewing its policy on this.

Public and staff engagement

- The trust performed similar to other trusts in the NHS Staff Survey 2013, but was in the top 20% for the following: the percentage of staff receiving job-relevant training; learning and development; fairness and effectiveness of procedures for reporting errors, near misses and incidents; experience of physical violence; experience of bullying or abuse from patients or bullying from patients, relatives or the public; staff experiencing harassment, bullying or abuse; staff able to contribute towards improvements at work; staff job satisfaction score; and experiencing discrimination at work. There were three negative outcomes: percentage of staff working extra hours; percentage of staff saying hand washing materials are always available; and staff motivation at work score. In the NHS Staff Survey 2014, the trust improved on all indicators, and was in the top 20% of trusts. Only one indicator was negative and below the England average, which was work pressures felt by staff.

- Most staff in the trust were positive about staff engagement. Action was being taken where concerns were identified, such as in diagnostic imaging, where the staff survey revealed that 42% of all staff felt subjected to harassment or bullying in the work place. A listening exercise was held to improve the environment for radiographers. There were areas, in outpatients, critical care and community hospice care, where staff did not feel listened to, and identified that no action had been taken.

- The trust runs a Friends and Family Test three times a year for staff to feedback on the services provided. The survey asked two questions: How likely are you to recommend (the hospital) to friends and family if they needed care or treatment? How likely are you to recommend (the hospital) to friends and family as a place to work? Recent results showed an 88% and 73% recommendation respectively. Some of the reasons staff gave for recommending the trust as a place to work included

excellent personal development, career progression and training opportunities; high quality staff support and pastoral care; positive working environment; good team ethos and collaborative interdisciplinary working.

- The trust holds an annual 'Hospital Heroes' award to recognise staff achievement.
- Many staff told us that communications were good. All staff told us about the CEOs blog, which was described as "excellent" and "inclusive". The trust had newsletters and the intranet, and teams held regular meetings to support staff engagement.
- The trust undertook a listening exercise with staff, in March 2013, led by the chaplaincy team, on compassionate care. Seventeen focus groups were undertaken and an educational film was commissioned for staff. A Compassion Operational Group was established in March 2014 to disseminate the learning and implement the subsequent recommendations.
- The trust had a Patient Experience Strategy Group, which met every six weeks to monitor the patient experience strategy. The group was a sub-group of the council of governors, and this enabled them to provide the trust with independent information. Improvement targets were set annually as part of the PIF. In 2014/15 there were targets on improving safeguarding, end of life care, support at mealtimes - particularly for older people, discharge, mixed sex accommodation and improving action on patient feedback. There were key performance indicators on the Friends and Family Test, same sex accommodation, and nutrition care plans for high risk patients. The trust was achieving its targets for the Friend and Family Test, but was not meeting other targets. The dashboard was not complete in terms of ongoing monitoring of all areas of the experience agenda.
- The patient and public involvement strategy was monitored by the patient experience group and included five pledges: to be clear and jargon free in communication; to be open and honest about decisions they can and cannot influence; to consult on services; to actively seek feedback and listen; and to tell people what has been done to improve services. The pledges were being enacted; for example, services were seeking feedback, although the main focus of this was the Friends and Family Test and this had not been widened to specific questionnaires; wards had noticeboards with 'You said, We did' and patient leaflets were written in plain English, although some signs, such as the sign for analgesia in the children's emergency department, were not.
- The trust had identified effective public engagement as an important way to improve patient care, and had undertaken a

number of initiatives and some public education work: there was an annual open day, community events, membership newsletters, the use of social media, and the CEO held patient lunches. There was effective partnership working with patient representatives, such as Southampton Children's Hospital Youth Partnership and the Local Learning Disability Partnership Board.

Innovation, improvement and sustainability

- The trust had a highly innovative culture, and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important to develop services in response to the needs of patients, increasing service demand, and financial constraints. There were many examples of service improvements developed by the trust and the staff.
- The trust, as a foundation trust, is regulated by Monitor. As part of its regulatory regime, Monitor assigns risk ratings to each foundation trust. The trust has a 2014/15 risk rating of two (out of 4) for continuity of service, indicating evidence of risk but its financial position is unlikely to get worse. This was based on the 18 week referral to treatment target, the four hour emergency access target, and other measures, including infection rates. The trust governance risk rating had changed from green (no evidence of concern) to 'under review' because of target breaches. Monitor is requesting further information before deciding on the next steps.
- The trust financial position meant that the board was having to make difficult decisions. This was no more emphasised, and was described as the 'toughest' by leaders, when the board decided to defer £5.5m of spending into 2015/16. The main schemes affected were the Children's Hospital emergency department and the modernisation of theatres. There are ongoing decisions on patient safety issues, where improvements were needed in the facilities and environment of the hospital buildings.
- The trust had a small surplus of £777k in 2013/14, and was expected to have a surplus of £3.2m in 2014/15. The charity build of Ronald McDonald House had provided an £8m financial asset to the trust this year, but otherwise finances would have been constrained by the number of emergency admissions. The trust was aiming to focus on commercial, research and development, and education opportunities to secure new income and mitigate financial risks. The strategy was also to redesign patient pathways, and introduce new technologies, and attract investment in healthcare. Although the strategic direction was clear, the planning around this was

less well developed and was informal in places; for example, the planning around rehabilitation had being over a 12 month period, but had not been discussed with commissioners at an early stage to garner support and investment. Investment in new technology was limited, and staff were using national resource schemes for technology they considered vital, such as electronic tablets to support the monitoring of patients on the wards.

- Further income was being generated through Commissioning for Quality and Innovation (CQUINS) priorities for the trust. These included dementia and delirium outcomes, improving response rates to the Friends and Family Test, and patient experience metrics. In addition, reducing patient follow-ups, and the roll-out of 'choose & book' were also priorities. The trust was demonstrating improvements in these areas.
- Cost improvement programmes had been identified, but the trust expected a shortfall of £1.8m by the end of the year. There had been some significant overspends, such as the sub-contracting out of the waiting lists to improve referral to treatment time targets. The trust had an action plan to address the shortfall, such as reducing agency spend and ensuring that the coding of clinical income is correct. The programme was monitored by the medical director and the director of nursing, so that actions taken to improve did not impact on quality.
- The trust had a research and development department to manage and co-ordinate research activity, and also to manage a range of external relationships. The trust's clinical research was linked to the University of Southampton, the Wellcome Trust and Cancer Research UK, and also to a number of other charities. Research teams worked closely with clinical staff and implemented innovations in clinical areas. The trust has research that has been recognised nationally and internationally, such as the work of the Allergy Clinic, who have been presented with a World Health Organization (WHO) award for excellence.

Overview of ratings

Our ratings for Southampton General Hospital

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

Our ratings for Princess Anne Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Countess Mountbatten House

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Good	Good	Good	Good

Overview of ratings

Overall	Good	Good	Good	Good	Good	Good

Our ratings for University Hospital Southampton NHS Foundation Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

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

Outstanding practice and areas for improvement

invited to write down on templates what had been 'tops' or 'pants' about their hospital stay. Children who were very young, and were unable to write, could still provide feedback.

- The children and young people's service used play leaders and youth support workers as advocates for children and young people. The service had an ethos of compassionate care and peer support, and social events were actively encouraged for children and for the parents of children with cancer, and long-term or chronic diseases.
- The trust had implemented a 'Ready, Steady, Go' initiative to support young people through the transition from children's to adult services. Young people were involved in deciding when they were transferred.
- The chaplaincy team held a listening exercise with staff to help identify what compassionate care meant for staff working at the trust. The 10 key recommendations from this report were now being implemented across the organisation.
- The bereavement support team were involved in the co-ordination of tissue transplantation. They explained how families could get involved, and supported families through the tissue transplant process. As a result of this service, tissue transplant donation had increased by 300% (from 20 tissue donations in 2011, to 60 donations in 2013/14).
- The Allergy Clinic within the outpatients department, had received a World Health Organization (WHO) award for excellence.
- Midwives who held a caseload (caseload midwives) worked in areas of greatest deprivation and with the largest number of teenage pregnancies. These midwives had smaller caseloads and provided greater continuity of care, and often followed the women into the maternity unit to deliver.
- There was a 'birth afterthoughts' service, which enabled women to have a debrief with a midwife following their delivery. Themes from this service were identified and fed into the governance process. Over 400 women had accessed the service during 2014.
- Women with hyperemesis could be cared for as day case patients and receive intravenous fluid rehydration. This meant they could remain at home and helped to prevent admission.
- A telephone triage service had been agreed with a neighbouring trust and was about to be implemented. This initiative would direct women to the appropriate place for care.

Areas for improvement

Action the trust MUST take to improve

The trust MUST ensure that :

- Nurse staffing is consistently at safe levels, to meet the needs of patients at the time and support safe care.
- Equipment is regularly tested and maintained, and a record of these checks is kept.
- There are suitable environments to promote the safety, privacy and dignity of patients in the cardiac short stay ward, G8 ward, and all critical care areas with level 1 patients.
- There is sufficient basic equipment in all departments and timely provision of pressure relieving equipment, beds and cots.
- The access and flow of patients across the Southampton General Hospital is improved. Discharge is effectively planned and organised, and actions are taken to improve delayed transfer of care discharges.
- All wards have the required skill mix to ensure patients are adequately supported with competent staff.
- No risks are posed to patient safety in the event of electrical failures in critical care areas.
- All risks associated with the cramped environment in critical care areas are clearly identified, and timely action is taken to address those risks.
- Overhead hoists in critical care units are correctly positioned and in working order, so they can be used, as intended, for patient care.

Outstanding practice and areas for improvement

- There is an effective process embedded into practice for alerting medical staff or the outreach nursing team in the event of patients deteriorating on the general wards.
- There is appropriate management of identified risks in the general intensive care unit (GICU).
- There is a definite plan to develop critical care services to meet the local and regional population's health needs; this plan is to include the provision of appropriate follow-up services.
- The specialist palliative care team reviews the level of medical consultant support.
- There are safe staffing levels in diagnostic imaging teams to prevent untoward safety incidents occurring.
- Incidents are reported by radiographers, and there is learning from all IR(ME)R and diagnostic imaging incidents, and processes for Duty of Candour are appropriately followed.
- The operating tables in maternity theatres can be lowered adequately, so surgeons are not required to stand on stools, which would otherwise increase the risk of back injuries to the surgeon and patient risks during surgery.
- All maternity staff are aware of the location or correct use of equipment for the safe evacuation of women from the birthing pools.

As a provider, the trust should ensure:

- Continue to improve complaints handling procedures, in particular to ensure that complaint responses address all identified concerns, lessons are learnt and overdue complaints are reviewed.
- Its clinical strategy is updated and implemented.
- Transformation and strategic plans are well developed, and formal processes with commissioners and partners are used effectively.
- Clinical quality dashboards are further developed at division, care group and ward level, and there is the ability to monitor the patient improvement framework at these levels.
- Risk registers are up to date, with appropriate mitigation and controls.
- The board assurance framework is developed and reviewed, to assurance around actual, anticipated and potential strategic and operational risks.
- Director's portfolios are clear and understood by staff.
- There is better leadership in services where this is of concern, including critical care and diagnostic imaging.
- Divisions continue to work together to improve patient pathways across the trust
- The trust completes a cultural safety survey.
- The equality and diversity strategy is integrated within the trust.
- The Fit and Proper Persons Requirement (FPPR) is implemented appropriately.

Please refer to the location reports for details of where the trust SHOULD also make improvements.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service. The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. · There was not an effective process in operation for alerting critical care, medical staff or the outreach team, in the event of patients deteriorating on the general wards. · Patients were not consistently discharged from the hospital in a timely fashion. This, along with a high number of delayed discharges, was having an impact on access and flow of all patients across the hospital. This delayed patient care and treatment in the appropriate ward or department. Regulation 9- 1 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 Health and Social Care Act 2008(Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The provider did not have effective systems to regularly assess and monitor the quality of services provided.

This section is primarily information for the provider

Compliance actions

· There were not robust and transparent reporting and learning from incidents occurring in diagnostic imaging services.

· There were not robust or timely plans in place to address the risks within critical care services.

· There were insufficient monitoring and identification of risks, or actions to address a range of risks in diagnostic imaging services.

· Mixed sex accommodation breaches were not appropriately identified, recorded and managed accorded to Department of Health Guidelines on cardiac short stay ward.

Regulation 10 (1) (a) (b) (2) (c) (i) (HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety and suitability of premises. The registered person had not ensured that service users using the premises were protected from the risks associated with unsuitable premises. · The environments in the cardiac short stay ward, G8 ward, and some critical care units with level 1 patients, did not promote the safety, privacy and dignity of patients. · Electrical failures in the general intensive care unit, affecting lighting and the working of monitors, posed a risk to patient safety. · The cramped environment in some critical care units created risks for staff and patients. Regulation 15 (a)(c)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. The provider did not have suitable arrangements to protect patients and staff against the risk of unsafe equipment, or the lack of availability of equipment. · Not all equipment was regularly checked or PAT tested. · The hoists in some critical care areas were poorly positioned, or out of order, so could not be used as intended for patient care. · There were some delays in the supply of pressure relieving equipment, beds and cots, as demand was not being met by the external contractor. · There was an insufficient supply of some basic equipment in some departments and wards. · One maternity operating table could not be lowered adequately, so surgeons were required to stand on stools, which increased the risk of back injuries. · Not all maternity staff were aware of the location or correct use of equipment for the safe evacuation of women from the birthing pools. Regulation 16 (1)(a)(b) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Staffing.

This section is primarily information for the provider

Compliance actions

The provider did not have suitable arrangements to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed.

· High levels of nurse vacancies were having an impact on consistency of staffing levels as planned, to support safe care. Nursing staff were moved across wards to try to mitigate risks; however, this led to concerns about lack of relevant skills to meet the needs of patients in different specialties.

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

· There was insufficient medical cover, particularly at consultant level, for end of life care services across the hospital.

Regulation 22) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20: Duty of Candour · The imaging department did not have procedures to demonstrate that the Duty of Candour was considered, implemented and followed for reportable incidents under IR(ME)R. Regulation 20 (1)(2)(3)(4) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.