Care Quality Commission

Hampshire Hospitals NHS Foundation Trust

# Andover War Memorial Hospital

## Quality Report

Andover War Memorial Hospital
Charlton Road
Andover
Hampshire
SP10 3LB
Tel: **01962 863535**
Website: www.hampshirehospitals.nhs.uk

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

## Ratings

| | |
|---|---|
| Overall rating for this hospital | Requires improvement |
| Urgent and emergency services | Requires improvement |
| Medical care | Good |
| Surgery | Requires improvement |
| Maternity and gynaecology | Good |
| End of life care | Outstanding |
| Outpatients and diagnostic imaging | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Hampshire Hospitals NHS Foundation Trust was established in January 2012 as a result of the acquisition by Basingstoke & North Hampshire NHS Foundation Trust of Winchester & Eastleigh Healthcare Trust.

The trust provides a full range of elective and emergency medical and surgical services to a local community of 600,000 patients in Basingstoke, Winchester, Andover and the surrounding areas in Hampshire and West Berkshire. It provides services from Andover War Memorial Hospital, Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital. Outpatient and assessment services are provided from Alton, Bordon and Romsey Community hospitals, and the Velmore Centre in Eastleigh.

Andover War Memorial Hospital (AWMH) was opened in 1926. The hospital provides inpatient rehabilitation, day hospital services and a minor injuries unit, and a new outpatient unit opened in 2010. The site also houses the Countess of Brecknock Hospice, which provides six inpatient beds, day care, and a base for Macmillan Nurses.

We inspected the hospital as part of our comprehensive inspection programme. We inspected six core services at this hospital: Urgent care services, medical (including older people) services, surgical services, maternity and gynaecology, end of life care and outpatient services. The hospital did not have critical care or services for children and young people.

There were 60 staff employed at the hospital.

The inspection of AWMH took place on 28 and 30 July 2015. The full inspection team included CQC senior managers county managers, inspectors and analysts. Doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers also joined this team.

We rated AWMH as overall as 'requires improvement'. We rated it as good for providing safe, caring, responsive services. However, MIU was rated as requires improvement for effective and well led services.

We rated the hospital's services for end of life care as 'outstanding'; for medical care, maternity and outpatients and diagnostics as 'good' and for the minor injuries unit and surgery as 'requires improvement'.

Our key findings were as follows:

**Are services safe?**

- Staff were encouraged to report incidents and learning from incidents to improve the safety of services locally and across the trust. However, in the Minor Injuries Unit (MIU) and in surgery, learning was not being effectively shared across the trust's services.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the Care Quality Commission.
- Patient clinical areas were visibly clean and staff followed good infection control procedures.
- Staffing levels were appropriate in all areas.
- Overall, staff had a good understanding of safeguarding adults and children. In the MIU there were pathways for children with non-accidental injury. However, safeguarding checks had not been consistently recorded in patient notes.
- Medicines were appropriately managed and stored. Action was being taken in areas where there were some concerns. The Patient Group Directions, which allows trained nurses to prescribe and administer drugs, were out of date in the MIU.
- Equipment was checked and stored appropriately in most areas but this needed to improve in the MIU, specifically for resuscitation equipment.
- More staff needed to complete mandatory training.

# Summary of findings

- Patients' were assessed and monitored appropriately. However, the early warning score needed to be used in surgery, and a scoring tool was required for outpatients, for patients whose condition might deteriorate. There also needed to be a clear hospital protocol for responding to a collapsed patient.
- The trust did not employ site security for the hospital. MIU staff were concerned about the number of recorded incidents of abuse from patients attending the MIU towards staff.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting system. Senior staff we spoke with were aware of duty of candour and talked about the importance of being open and transparent with patients and their families

**Are services effective?**

- Staff were providing care and treatment to patients based on national and best practice guidelines. In some areas guidelines had been unified across the trust for consistency of care. However, the MIU did not have clear guidelines or protocols for the management of common conditions. Staff in surgery did not all know how to access the trust's guidelines and protocols and some policies they were using were out of date.
- Most services were not monitoring the standards of care and treatment. Patient outcomes, where available, were similar to the England average or within expected range.
- Patients received good pain relief in the MIU, after surgery and in end of life care. The Maternity Centre used hypnotherapy-birthing techniques to support women in pain during labour.
- Patients, particularly older patients, were supported to ensure their hydration and nutrition needs were met.
- Staff were supported to access training and there was evidence of staff appraisal and supervision. Nursing and midwifery staff were autonomous, experienced and competent practitioners. However, staff in the MIU were not supported to keep their clinical skills up to date through supervision or developmental training, and day surgery staff did not have regular and up to date competency assessments. Midwifery staff told us they did have opportunities for professional development.
- Staff worked effectively in multidisciplinary teams to centre care around patients. There were innovations in electronic records and the use of video conferencing in end of life care that enabled information to be shared about patient's clinical needs and preferences across the trust, and with community and GP services.
- Seven-day services varied. These were developed in the MIU, the Maternity Centre and the hospice. However, day surgery occurred Monday to Friday and medical patients did not receive therapy input for rehabilitation over the weekends. There were a high number of repeat attenders to the MIU because there was no radiology at the weekend.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission. However, the capacity assessments were not always documented or regularly reviewed in patient care records.
- 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms had been fully completed.

**Are services caring?**

- Staff were caring and compassionate and treated patients with dignity and respect. Patient feedback was positive across all services. The Countess of Brecknock Hospice provided outstanding care with patients and relatives providing examples where staff had gone "above and beyond" and developed trusting relationships to provide personalised care and support to patients and their families.
- Staff maintained patient's confidentiality, privacy and dignity in all areas.
- Patients and their relatives felt involved in their care and treatment, staff provided explanations in the way patients could understand. Patients felt that their views and considerations were listened to and acted upon.

# Summary of findings

- Patients and their families were supported emotionally to reduce anxiety and concern, particularly for example, in preparation for surgery, or for women during labour. There was support for carers, family and friends from the chaplaincy and bereavement services for patients having end of life care.
- Data from the NHS Friends and Family Test demonstrated that patients were very satisfied and would recommend the care they received.

**Are services responsive?**

- The MIU service saw and treated patients within the national emergency access target of four hours.
- Medical patients did not have to wait for access to the Kingfisher ward and there was active therapy input to commenced rehabilitation immediately. Discharge planning was supported but there were delayed transfers of care.
- The trust was achieving the 18-week referral-to-treatment time target for medical patients. The target had been met in surgery between April to December 2014 but was not being met between January to March 2015. The target was not being achieved in orthopaedics and ophthalmology.
- The majority of patient who had cancelled surgical procedures for non-clinical reasons were rebooked for surgery within 28 days. Some operations and procedures were being cancelled because of absent medical records.
- Patients did not have staggered admission times for all procedures as recommended, to limit fasting and waiting times on the day of surgery.
- Women were able to make choices about where they would like to deliver their babies. They had access to their preferred ante-natal clinics and women in the early stages of labour had access to telephone support.
- There were one stop gynaecology, cataract and orthopaedic clinics.
- The trust was meeting national waiting times for diagnostic imaging within six week, outpatient appointments within 18 weeks and cancer waiting times for urgent referral appointments within 2 weeks and diagnosis at one month and treatment within two months.
- The trust cancellation rate for appointments was 13%; the England average was 7%. Many of these clinic cancellations were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments.
- Some patients had long waiting times whilst waiting in clinic for diagnostic imaging, and there could be delays of up to an hour.
- Support for patients living with dementia or a learning disability was well developed for medical care, but was not consistent for patients undergoing surgery.
- There was access to the breast unit at Winchester, which offered access to one stop clinics. Appointments were offered to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by consultants. Patients who attended the one stop clinics would see a clinician, have a biopsy taken and see a radiologist if required. If a cancer diagnosis was suspected, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options. This unit provided a responsive service for patients who were anxious about a potential cancer diagnosis.
- There was a hospital at home service to deliver care to those patients identified as being in the last days or hours of life. The service was 24 hours and seven days a week. Multidisciplinary team working, and innovations in electronic records and the use of video conferencing in end of life care, also facilitated rapid assessment and access to equipment.
- Patients having end of life care had multi-disciplinary care focused on their physical, mental, emotional and social needs. Patients could have a rapid discharge to home arranged within 24 hours. However, there were delays to the rapid and fast track discharge processes (within 48 hours) and processes were being improved to meet national standards.
- Complaints were handled appropriately and there was evidence of improvements to services as a result.

# Summary of findings

**Are services well-led?**

- All services identified the plans to build a new Critical Treatment Hospital as the overall strategy for the trust, and there were in-depth plans towards this across services. However, the individual services did not have specific strategies and plans in the short and medium term for their development. Priorities were identified to increase capacity and staffing.
- Clinical governance arrangements varied across the hospital. The Kingfisher Ward (medical care), Maternity Centre and Countess of Brecknock Hospice had effective arrangements to assess and manage the quality of service provision. However, the MIU, day care unit for surgery and outpatient department required more robust arrangements to effectively monitor the quality of the service, clinical standards and to mitigate risks.
- Many staff told us overall they had good support from the local clinical leaders, for example ward managers and clinical leads.
- Staff engagement also varied and was good in some areas, but there was a disconnect with the trust's working arrangements in the MIU, Day Care Unit and outpatient department, and staff did not feel part of the wider trust.
- Many staff identified the visibility, approachability and support of the chief executive of the trust.
- The leadership for end of life care was outstanding. There were robust governance arrangements and an engaged staff culture, all of which contributed to driving and improving the delivery of high quality person-centred care. This was an innovative service with a clear vision and supportive leadership and board structure.
- Patient engagement was mainly through survey feedback, although the Maternity Centre also used social media.
- Innovative ideas and approaches to care varied. This was being encouraged and supported on the Kingfisher Ward (medical care), in maternity and end of life care, and there were good examples of innovations in care. This was less evident in the MIU, the day care unit for surgery, and outpatient and diagnostic imaging services.
- The non-clinical site manager was a highly-valued member of staff.

We saw several areas of outstanding practice including:

- Kingfisher ward had activity coordinators who planned and conducted different activities for patients after consulting them. There was a range of activities offered, including arts and crafts, music, dance, group lunches and movie time.
- Pregnant women were able to call Labour Line which was the first of its kind introduced in the country. This services involved midwives based at the local ambulance operations centre. Women who called 999 could discuss their birth plan, make arrangements for their birth and ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners. Labour Line midwives were able to prioritise ambulances to women in labour if they were considered an emergency. The continuity of care and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour. The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015, and they were also awarded second place in the Midwifery Service of the Year Award.
- The specialist palliative care team provided a comprehensive training programme for all staff involved in delivering end of life care.
- The cardiac palliative care clinic identified and supported those patients with a non-cancer diagnosis who had been recognised as requiring end of life care.
- The hospice at home service was proactive in supporting patients in their own home.
- The use of the butterfly initiative promoted dignity and respect for the deceased and their relatives.
- There was strong clinical leadership for the end of life service with an obvious commitment to improving and sustaining care delivery for those patients at the end of their lives. All staff throughout the Countess of Brecknock Hospice were dedicated to providing compassionate end of life care.

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

Importantly, the trust must ensure:

# Summary of findings

- MIU staff have access to up- to-date approved Patient Group Directions (PGDs).
- MIU staff must all have received update mandatory training in basic life support and infection control
- Safeguarding checks are consistently completed and recorded.
- Resuscitation equipment is appropriately checked and equipment is sealed and tagged.
- There is a clear hospital protocol for responding to a collapsed patient in an emergency.
- There is appropriate security on site for the protection of staff and patients in the MIU.
- The lead consultant for ED should regularly monitor and maintain clinical standards in the MIU
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- There is an effective system to identify, assess, monitor and improve the quality and safety of the MIU, the day care unit and outpatient services

In addition, the trust should ensure:

- Staff receive appropriate training, and there is a formal process in place for staff to follow to meet requirements of the Duty of Candour.
- The availability of medical notes for outpatient clinics continues to improve and this should be audited.
- There is a formal method to identify patients whose condition might deteriorate in the outpatient clinic.
- Patients receive better access to therapy services to continue rehabilitation over weekends.
- Clean equipment is clearly identified for use and is appropriately separated from dirty equipment.
- Bariatric equipment is available when required.
- Continue to recruit to support radiographers, and assess the impact of vacancies on staff.
- All staff have appropriate clinical supervision.
- The Maternity Centre has better access to defibrillator equipment.
- Medicines are appropriately stored in the Maternity Centre.
- Clinical audit programmes are developed in all services.
- Information is being measured, monitored and recorded regarding outcomes for women.
- Theatre capacity is reviewed and patients are not waiting longer than 18 weeks for surgery.
- Patient have staggered admissions for day surgery.
- Patient operations are not cancelled on the day of surgery for non-clinical reasons.
- Patient's privacy and dignity is maintained on the day care unit by reviewing same sex arrangements.
- There is service continuity with local funeral directors to collect deceased bodies from the Countess of Brecknock Hospice, to reduce the risk of any services being withdrawn.
- The process for 'fast-track' discharge for end of life care is reviewed so that the standard is met.
- Improve staff engagement in the MIU, day surgery unit and outpatients.
- There are formal methods to feedback complaints to staff.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Urgent and emergency services | Requires improvement  | We found the minor injury unit (MIU) was good for caring and responsive services but required improvements to provide safe, effective and well-led care.<br>There were insufficient processes for identifying, assessing and managing risks in the service. Staff did not have access to up to date guidance and protocols and were not supported through clinical supervision. The clinical standards of the service were not monitored in line with the MIU service specification. Staff did not have regular contact with the consultant lead for the service and most staff could not name the consultant lead. There was a disconnect between the operation of the unit and the senior governance processes in the trust. Staff did not feel their concerns were managed effectively and this had impacted on staff morale. The trust had recently recognised the leadership issues within the MIU service and was in the process of reviewing the current arrangements to ensure better and closer liaison with the ED's at the other two sites.<br>Processes to protect patients from risks were not always followed. Learning from incidents was not consistently shared between the MIU and trust's main emergency departments. There was no record of the daily check of resuscitation equipment, and we found some items in the resuscitation trolley were out of date. Not all staff were up to date with mandatory training or had completed updated training in basic life support. The MIU reference file of Patient Group Directions (PGDs) contained some which were out of date with different versions of the same PGDs, which increased the risk of error. However, the MIU was organised and equipment was visibly clean. Medicines were appropriately managed and stored. Staff were adherent to infection control procedures, We observed caring and compassionate interactions between staff and patients. There was one vacancy for an emergency nurse practitioner and low rates of staff sickness. There was a supportive team culture within the |

# Summary of findings

ENPs and clinical nurse assistants. Safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place.
Patients' presenting to MIU were assessed and in case of deteriorating conditions, appropriate action was taken. However, staff said they were not clear about the hospital protocol for responding to a collapsed patient elsewhere on the site.
Staff provided compassionate care and ensured that patients were treated with dignity and respect. We observed patient's privacy and dignity was maintained at all times. The results of the NHS Friends and Family Test (FFT) showed that a higher than average number of patients would recommend the department, although this was based on a low response rate. Patients were fully involved in the assessment and treatment process.
The service met the national emergency access target for 95% of patients to be admitted, transferred or discharged from the MIU within four hours.
Staff described the chief executive as accessible and approachable through her monthly visits to the hospital.

## Medical care

**Good**

We found that medical care (including older people's care) was 'good' for safe, effective, caring, responsive and well led services.
Our key findings are:
Process and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents and the learning from incidents was used to improve the service. The ward environment was clean and equipment was available and well maintained. Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm free care. Safeguarding protocols were in place and staff were familiar with these. Nursing staffing levels were appropriate; junior doctors were present during weekdays and there were arrangements for on call medical cover at the weekend.
There were appropriate procedures to provide effective care. Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines.

# Summary of findings

Patients were cared for by a multidisciplinary team working in a co-ordinated way and staff had good access to training. There were effective arrangements to ensure that staff had the necessary skills and competence to care for patients; staff had good access to training and professional development opportunities. When patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements. However, the capacity assessments were not always documented in patient care records.

Patients received compassionate care from staff that respected their privacy and dignity. Patients told us they felt involved in decision making about their care. We found staff were caring and compassionate. Patients we spoke with praised staff for their empathy, kindness and caring. There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.

Patients were not waiting for access to rehabilitation to Kingfisher ward and once admitted rehabilitation was commenced immediately with active therapy input. Patients who were medically declared fit and needing further rehabilitation input were transferred from RHCH and BNHH to Kingfisher ward. Occasionally patients were also admitted from other acute NHS trust hospitals in the locality or referred by GP's. Patients regularly received medical input and were regularly seen by the therapists who assisted the patients to work towards their rehabilitation goals. The ward based social worker supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS funded continuing care.

The data provided by the trust demonstrated there were an increasing number of delayed transfers of care (January 2015 to May 2015). We were told by the social worker and nursing staff on the ward that the main cause of delays was the provision of community services, especially care home placement, to meet patients' on-going needs.

The medical services had a long-term strategy and priorities around improving the services this included improving the pathway for frail elderly

patients. There were not however, specific plans for the development of the service in Andover. There were effective governance arrangements and staff felt supported by service and trust management. Lessons from incidents and complaints were usually shared within the staff.
The culture on the Kingfisher ward was caring and supportive. Staff were actively engaged and innovation and learning was supported. There was good local leadership at ward level. The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service.

## Surgery

**Requires improvement**

We found that surgery was good for safe and caring services. We rated effective, responsive and well-led services as requiring improvement.
Our key findings are:
Incidents were reported on the trust electronic system and actions were taken at local level, although staff did not always share lessons learnt across the trust. The day care unit was clean and well maintained and infection control procedures were followed. Emergency equipment, such as a resuscitation trolley was available and checked regularly to ensure it was fit for purpose.
The service used the Five Steps to Safer Surgery checklist although this was not audited locally.
Patients were risks assessed and monitored. However, an early warning score was not used as a formal process to monitor and escalate patients whose condition might deteriorate. Staffing levels were appropriate to the needs of patients.
Staff provided care to patients based on national guidance and evidence based practice. However, standards of care and patient outcomes were not being monitored through a clinical audit programme. Patient outcomes were measured for cataract surgery and the complication rate was low. Patient's pain was appropriately assessed and treated.
Patients for endoscopy were admitted at varying intervals during the day. However, patients undergoing orthopaedic and cataracts procedures did not have staggered admissions which is recommended to limit fasting and waiting times.
Staff had access to training to maintain their skill. However, their competencies were not regularly

# Summary of findings

assessed. Staff worked in a multi-disciplinary way to provide care. GPs received discharge summaries in a timely way and there was a service level agreement for transfer of patients within the trust. Patients received care and treatment from staff who were caring and in a compassionate way. Staff across the day care unit treated patients with kindness and respect. Patients were involved in their care and treatment. Procedures had been fully explained and options discussed. Patients received emotional needs, were supported, and they felt prepared for their surgical procedures.

There was no evidence of service planning to meet local needs and the service was currently using less than 50% of its theatre capacity. Some referral to treatment times were not being met in orthopaedic surgery and ophthalmology and patients were waiting over 18 weeks for surgery. Treatment times were being met in dermatology, gynaecology and urology. Patient operations and procedures were being cancelled on the day of surgery because patient records were not always available. This was not being monitored and improvements had not occurred. The service had one stop clinics and was developing a bowel diagnostic service.

Support for patients living with dementia or who had a learning disability was not consistently being accessed or used by staff. The day care unit did not provide separate or same sex facility as care was provided in an open unit which may compromise patients' privacy and dignity.

The day care unit service at Andover hospital did not have a specific strategy for development. Staff were engaged, and felt connected to the trust, via the chief executive visits to the hospital. However, they were less engaged with the trust and their own surgical division. They did not, for example, participate in governance meetings or were aware of governance matters which may affect the service. Governance processes were at divisional level and were underdeveloped in the unit. There was limited evidence of local audit or monitoring of the service quality and risks.

# Summary of findings

Staff were positive about the local leadership of the service and felt supported by their immediate managers and worked well together. Patient feedback, via the Friends and Family test was used to improve the service.

## Maternity and gynaecology

**Good**

We found maternity services were good for providing safe, effective, caring, responsive and well led services.
Our key findings are:
Midwifery staff were encouraged to report incidents and robust systems were in place to ensure lessons information and learning was disseminated trust wide.Procedures to protect people from abuse and avoidable harm were being followed. Midwife staffing levels were appropriate to provide one to one care.
Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance. Policies and guidelines were developed in line with the Royal College Of Gynaecologists (RCOG), Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust for the maternity service to ensure all services worked to the same guidelines.
Although patient outcomes were recorded on the trust wide maternity dashboard, outcomes appropriate for a midwifery led centre were not being measured and recorded. This needed further development.
Women throughout the service consistently gave us positive feedback about the care and treatment they had received. We observed women were treated with dignity and respect and were included in decision making about their care. Women were able to make choices about where they would like to deliver their babies. Women and families had access to sufficient emotional support if required.
There was a strategy and vision for the service which was focused towards the development of a new hospital. However, there was not a specific strategy or plans for the maternity centre in the short and medium term. The overall plan was for

the service to remain open to increase choice for women but the plans to increase birth rates or expand and develop the service were not developed.
There were comprehensive risk, quality and governance structures and systems were in place to share information and learning. Staff across the service described an open culture and felt well supported by their managers. Staff continually told us they felt "proud" to work for the trust.

## End of life care

**Outstanding** 

End of life care at this hospice was "outstanding". We rated the service good for safe, effective and responsive care and outstanding for caring and well-led care.
Our key findings are:
People were protected from avoidable harm and abuse. There were reliable systems and processes were to ensure the delivery of safe care.
Care and treatment was delivered in line with local and national guidance and, a holistic patient-centred approach was evident.
There was good multidisciplinary working, staff were appropriately qualified and had good access to a comprehensive training programme dedicated to end of life care.
Patient outcomes were routinely monitored and where these were lower than expected, comprehensive plans had been put in place to improve. 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms had been completed.
Staff treated people with compassion, kindness, dignity and respect and feedback from patients and their families were consistently positive.
People's needs were mostly met through the way end of life care was organised and delivered. However, the rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way. Where delays to discharge had occurred, these were mostly subject to circumstances outside the control of the trust.
The leadership for end of life care was strong. There were robust governance arrangements and an engaged staff culture all of which contributed to driving and improving the delivery of high quality person-centred care.

# Summary of findings

This was an innovative service with a clear vision and a strong focus on patient centred care and was supported by a board structure that believed in the importance of good end of life care for the local population

## Outpatients and diagnostic imaging

**Good**

Outpatients and diagnostic imaging services were good for providing safe, caring, responsive services, but required improvement to provide well-led services.

Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission.

The environments were visibly clean and staff followed infection control procedures. Equipment was well maintained and medicines were appropriately managed and stored. Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used. Patients were assessed and observations were performed, where appropriate. However, there was not an assessment tool in use to identify patient's whose condition might deteriorate.

Nurse staffing levels were appropriate as there were few vacancies. Radiographer vacancies were higher and they reported a heavy workload. There was an ongoing recruitment plan.

There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in rheumatology and ophthalmology. However, there was not a local audit programme to monitor clinical standards. Staff had access to training and had annual supervision but did not have formal clinical supervision.

Staff followed consent procedures but did not have an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.

Patients consistently told us that they had experienced a good standard of care from staff across outpatients and diagnostic imaging services.

# Summary of findings

We observed compassionate, caring interactions from nursing and radiography staff. Patients told us that they were included in the decision making regarding their care and treatment and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.

There was some evidence of service planning to meet people's needs. For example, the breast unit offered access to one stop clinics where patients could see a clinician, have a biopsy and see a radiologist if required. National waiting times were met for outpatient appointments, cancer referrals and treatment and diagnostic imaging. However, the trust had a higher number of cancelled clinics, many of which were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments. Some patients had long waiting times whilst waiting in clinic for diagnostic imaging, and there could be delays of up to an hour.

There was good support for patients with a learning disability or living with dementia. Patients whose first language might not be English had access to interpreters although some staff were not aware of how to access this service. The service received very few complaints and concerns were resolved locally. Staff were not aware of complaints across the trust or the learning from complaints.

The outpatient department had a strategy in development. There were plans to deliver local consultant led services, including more one stop, nurse led and complex procedure clinics for outpatient services. Staff were not aware of how the strategy would develop in their departments and there were no immediate plans to tackle capacity issues and clinic cancellations. In diagnostic imaging there was an action plan planned to increase the skill mix of staff, the capacity of services and service integration across sites. This had had yet to be considered at divisional and trust board levels and interim actions were not specified.

# Summary of findings

Governance processes required further development in the outpatient department to monitor risks and quality although these were well developed in diagnostic imaging.
Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Staff identified a disconnect with local services and the wider trust. Many staff in outpatients did not see their service leads frequently and said that trust board members did not have a visible presence.
Nurses and radiographers spoke highly of their immediate line managers and told us they worked in strong, supportive teams which they valued. There were however, few examples of local innovation and improvement to services. In diagnostic imaging, a staff representative role was being introduced to support and implement positive changes within the department that staff members themselves had recommended.
Public and patient engagement occurred through feedback such as surveys and comment cards.

# Andover War Memorial Hospital

## Detailed findings

**Services we looked at**Urgent & emergency services; Medical care (including older people's care); Surgery; Maternity and Gynaecology; End of life care; Outpatients & Diagnostic Imaging.

# Detailed findings

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## Background to Andover War Memorial Hospital

Hampshire Hospitals NHS Foundation Trust was established in January 2012 as a result of the acquisition by Basingstoke & North Hampshire NHS Foundation Trust of Winchester & Eastleigh Healthcare Trust. The trust provides acute hospital services to approximately 600,000 patients in Basingstoke, Winchester, Andover and surrounding areas in Hampshire and West Berkshire.

The trust provides services from Andover War Memorial Hospital, Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital. Outpatient and assessment services are also provided from Alton, Bordon and Romsey community hospitals, and the Velmore Centre in Eastleigh.

Andover War Memorial Hospital was opened in 1926. The hospital provides inpatient rehabilitation, day hospital services and a minor injuries unit, and a new outpatient unit opened in 2010. The site also houses the Countess of Brecknock Hospice, which provides six inpatient beds, day care, and a base for Macmillan Nurses.

We inspected the hospital as part of our comprehensive inspection programme. We inspected six core services at this hospital: Urgent care services, medical (including older people) services, surgical services, maternity and gynaecology, end of life care and outpatient services. The hospital did not have critical care or services for children and young people.

## Our inspection team

**Chair:** Professor Bob Pearson, Medical Director, Central Manchester University Hospitals NHS Foundation Trust

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

The team of 46 included CQC managers, inspectors and analysts, and a variety of specialists including: Consultant gynaecologist and obstetrician; consultant surgeons; consultant anaesthetist; consultant physicians; consultant geriatricians; consultant radiologist; consultant in clinical oncologist; consultant paediatrician; specialist registrar doctors with experience in emergency medicine and critical care; consultant nurse in paediatric emergency department; midwife; gynaecology nurse; surgical nurses; theatre nurse; medical nurses; paediatric nurses, neonatal nurse specialist, palliative care specialist nurse; critical care nurse; outpatient manager, board-level clinicians and managers, a governance lead; a safeguarding lead; a student nurse; and experts by experience.

# Detailed findings

## How we carried out this inspection

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

We carried out an announced inspection visit to Andover War Memorial Hospital on 28 and 30 July 2015.

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

The CQC inspection model focuses on putting the service user at the heart of our work. We held two listening events in Winchester and Basingstoke on Wednesday 22 July 2015 when people shared their views and experiences of the Hampshire Hospitals NHS Foundation Trust.

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

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

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

## Facts and data about Andover War Memorial Hospital

AWMH is the community hospital provided by Hampshire Hospitals NHS Foundation Trust, within the town of Andover.

Context:

- AWMH has around 38 beds: the entire trust has 1024 beds.
- The local population is around 600,000 people, from Basingstoke, Winchester, Andover and surrounding areas in Hampshire and West Berkshire.
- The number of staff is around 58 WTE of which 34 WTE are nursing staff. 5124 staff work across all trust locations; some staff work across all sites so an exact specific for AWMH is not possible.
- There were 15,003 MIU attendances at this site during April 2014-March 2015. During May 2014-April 2015, there were 38,306 outpatient appointments.

1. **Safety (trust wide)**

Between May 2014 and April 2015 there were 0 never events at this trust, and 3 serious incidents.

There were 62 incidents recorded by the trust on this site for the time period January 2015 to April 2015.

1. **Effective (trust wide)**

There is no information available at site level for this domain.

1. **Caring (trust wide)**

There is no information available at site level for this domain.

1. **Responsive (trust wide)**

Between April 2014 and March 2015, this hospital received 16 complaints. Please note that three complaints were not identifiable to a specific site.

1. **Well led (trust wide)**

There are 58.5 (WTE) nursing and other clinical staff working at this site. The numbers (WTE) of staff by staff type are given below.

# Detailed findings

| | WTE (Apr/15) | |
|---|---|---|
| Establishments | | |
| Nurses | 34.43 | 38.15 |
| Other | 24.07 | 23.44 |
| Total | 58.50 | 61.59 |

These staff members cover 28 inpatient and 10 day case beds.

1. **CQC intelligent monitoring**

There is no information available at site level for CQC intelligent monitoring.

## Our ratings for this hospital

Our ratings for this hospital are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Urgent and emergency services** | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| **Medical care** | Good | Good | Good | Good | Good | Good |
| **Surgery** | Good | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| **Maternity and gynaecology** | Good | Good | Good | Good | Good | Good |
| **End of life care** | Good | Good | ☆ Outstanding | Good | ☆ Outstanding | ☆ Outstanding |
| **Outpatients and diagnostic imaging** | Good | Not rated | Good | Good | Requires improvement | Good |
| **Overall** | Good | Requires improvement | Good | Good | Requires improvement | Requires improvement |

### Notes

# Urgent and emergency services

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

## Information about the service

The Minor Injuries Unit (MIU) at Andover War Memorial Hospital is located in a purpose built department. The unit is led by emergency nurse practitioners (ENPs) who are experienced in treating minor injuries and illnesses. It aims to serve the population of West Hampshire. The unit is open from 8:30am to 9:30pm every day and is also supported by x-ray facilities from Monday to Friday, 9am to 5pm.

The MIU saw 17,425 patients between 1 April 2014 to 31 March 2015, and 4,799 patients between 1 April 2015 to 30 June 2015.

During our inspection, we spoke with one patient, five members of staff including ENPs and clinical assistants. We observed interactions between patients and staff, considered the environment and looked at care records. We reviewed documentation from stakeholders and performance information from the trust.

## Summary of findings

We found the minor injury unit (MIU) was good for caring and responsive services, but required improvements to provide safe, effective and well-led care.There were insufficient processes for identifying, assessing and managing risks in the service. Staff did not have access to up to date guidance and protocols, and were not supported through clinical supervision. The clinical standards of the service were not monitored in line with the MIU service specification. Staff did not have regular contact with the consultant lead for the service and most staff could not name the consultant lead. There was a disconnect between the operation of the unit and the senior governance processes in the trust. Staff did not feel their concerns were managed effectively, and this had impacted on staff morale.

The trust had recently recognised the leadership issues within the MIU service, and was in the process of reviewing the current arrangements to ensure better and closer liaison with the ED's at the other two sites.

Processes to protect patients from risks were not always followed. Learning from incidents was not consistently shared between the MIU and trust's main emergency departments. There was no record of the daily check of resuscitation equipment, and we found some items in the resuscitation trolley were out of date. Not all staff were up to date with mandatory training or had completed updated training in basic life support. The

# Urgent and emergency services

MIU reference file of Patient Group Directions (PGDs) contained some which were out of date, with different versions of the same PGDs, which increased the risk of error.

However, the MIU was organised and equipment was visibly clean. Medicines were appropriately managed and stored. Staff were adherent to infection control procedures, and we observed caring and compassionate interactions between staff and patients.

There was one vacancy for an emergency nurse practitioner and low rates of staff sickness. There was a supportive team culture within the ENPs and clinical nurse assistants. Safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place.

Patients' presenting to MIU were assessed and in case of deteriorating conditions, appropriate action was taken. However, staff said they were not clear of the hospital protocol for responding to a collapsed patient elsewhere in the hospital.

Staff provided compassionate care and ensured that patients were treated with dignity and respect. We observed that patient's privacy and dignity were maintained at all times. The results of the NHS Friends and Family Test (FFT) showed that a higher than average number of patients would recommend the department, although this was based on a low response rate. Patients were fully involved in the assessment and treatment process.

The service met the national emergency access target for 95% of patients to be admitted, transferred or discharged from the MIU within four hours.

Staff described the chief executive as accessible and approachable through her monthly visits to the hospital.

## Are urgent and emergency services safe?

Requires improvement

**By safe, we mean that people are protected from abuse and avoidable harm.** We rated safe as 'requires improvement'.

Staff used the trust's electronic incident reporting system, but some staff had not received feedback from incidents, and learning from incidents was not shared across the trust.

The unit did not have a checklist for checking equipment and we found that some items of resuscitation equipment were out of date. Not all staff were up to date with mandatory training or had completed updated training in basic life support.

The MIU file of Patient Group Directions (PGDs) contained old and up dated versions of the same PGDs which increased the risk of error.

The trust did not employ site security for the hospital. MIU staff were concerned about the number of recorded incidents of abuse from patients attending the MIU towards staff.

Staff had a good understanding of safeguarding adults and children and had attended training. There were pathways in place for children with non-accidental injury. However, safeguarding checks had not been consistently recorded in patient notes.

Patients' presenting to MIU were assessed and in case of deteriorating conditions, appropriate action was taken. However, staff said they were not clear of the hospital protocol for responding to a collapsed patient elsewhere in the hospital.

The environment was visibly clean and organised. Infection control procedures across the department were followed and medicines were appropriately stored. There were sufficient numbers of qualified staff employed to deliver the service. Patient records were appropriately maintained and securely stored. **Incidents**

- Staff were aware of their responsibility to report incidents, using the trust's electronic reporting system

- Between January and April 2015 a total of 11 incidents were reported for the MIU. All but one were classified as no harm, one was classified as low harm. There were no serious incidents requiring investigation.
- Feedback from incidents was not consistent. One out of two nurses we spoke with said they did not receive feedback from the incidents reported or were aware of analyses of incidents or themes identified. One nurse said they received feedback from incidents they reported via email.
- Staff told us sharing learning from incidents which occurred at the trust's main emergency departments did not take place.

**Cleanliness, infection control and hygiene**

- All areas of the MIU including treatment rooms, waiting rooms and offices were visibly clean and dust free.
- Hand washing facilities were available and notices were on display advising staff, patients and visitors to wash their hands. Hand gel dispensers were also available.
- We observed nurses working 'bare below the elbow', which meant no watches, sleeves or jewellery were worn; this was in line with the trust's uniform policy. Staff had access to, and were using, personal protective equipment such as gloves and aprons.
- Clinical waste was managed safely. We observed sharps bins were not overfilled and were correctly labelled.
- Trust records for April 2014 to March 2015 identified that only 38% of the MIU staff had completed infection control training.
- Weekly cleaning audits against the National Cleaning Standards were undertaken, which showed 100% scores consistently for the previous three months. A full environmental audit including hand hygiene audit was undertaken in June 2015. This demonstrated good compliance with infection control policies and procedures.

**Environment and equipment**

- The area behind the reception desk contained a panic alarm, and CCTV camera allowed nurses to monitor the waiting room from the staff area. This meant that if an unwell patient arrived while the reception was unmanned, nurses could attend to them quickly. Nurses could also see how many patients were waiting and if they needed to go into the waiting room to prioritise care.
- Three nursing staff expressed concern about the absence of security on site. We noted seven of the 11 incidents reported (1 April 2014 to 31 March 2015) were categorised as abusive behaviour by patients towards staff.
- Staff told us they had access to sufficient equipment which was suitably maintained.
- The unit had appropriate resuscitation equipment. However, there was no checklist to record that all equipment was checked daily. We found some expired equipment on the resuscitation trolley, including airway devices (laryngeal mask airway sizes 4&5 had expired in November 2014, the nasopharyngeal airway had expired March 2015, and defibrillator pads had expired in June 2015). The staff were made aware of this and the old equipment was replaced.

**Medicines**

- Medicines were stored securely in the unit to ensure access was only by authorised staff.
- Some of the Patient Group Directions (PGDs) available in the MIU were out of date and were not indexed to allow ease of reference. PGDs are the formal written arrangements for nurses to administer medicines to their patients during treatment.
- The MIU file of PGD's sometimes contained duplication. For example, PGDs for ibuprofen, lignocaine, paracetamol and high flow oxygen. This had the potential for impacting safe patient care if the incorrect version was referred to. One member of nursing staff had created their own reference file of up to date PGDs to refer to.
- The MIU had a small stock of controlled drugs, and the registers were up to date, with no expired drugs in the cupboards. The medications were checked and recorded appropriately.
- The medication fridge was clean and not over full. Fridge medications were in date and the daily fridge temperature record check showed readings were within range and regularly monitored.

**Records**

- Records for patients attending the MIU were paper based during their stay in the department. We saw a sample of completed paediatric records. These were scanned to the computer in order to maintain a complete patient record. This allowed ease of access if a patient re-attended.

- The original paper records were disposed of using an outside contractor providing secure shredding to ensure patient information was kept safe.
- Records were kept electronically, and staff accessed the computer data bases through individual smart cards which were password protected. The data was also backed up to prevent loss.

### Safeguarding

- Staff had a good understanding of safeguarding awareness and could clearly describe the procedures they would follow if concerns arose.
- MIU nursing staff were required to attend at a minimum, level two child safeguarding training. Trust records for April 2015 showed all staff were up to date with safeguarding training.
- The Joint Children's Protection Register (a system for checking if children have been at risk of abuse) was available for checking within the department. There was a clear pathway on display for the management of potential non-accidental injury.
- We reviewed three sets of children's notes. Two out of three had safeguarding checks completed. Nurses completed a safeguarding children's liaison form which included consent to inform social services, if appropriate.
- Staff had access to the local domestic abuse guidelines and support available for patients.

### Mandatory training

- The trust's requirement for mandatory training included basic life support, infection control, moving and handling, fire safety, information governance, conflict resolution and safeguarding children and adults.
- The MIU was compliant with mandatory training against the trust target of 80% for most training except for basic life support (25%) and infection control (38%).
- Figures for advanced life support training were unavailable for MIU.
- All training was logged on the intranet and staff and managers could track compliance.
- Most training was provided as e-learning

### Assessing and responding to patient risk

- Patients were seen in the MIU using a formal 'assess and treat' process. This was carried out by the receptionist who was also trained as a clinical nursing assistant (CNA). The clinical nursing assistant was trained to identify patients who presented as very unwell. In such instances they would call the patient straight through to the treatment area and interrupt a nurse to alert them to a priority patient.
- If patients became seriously ill or had a cardiac arrest, a 999 ambulance was called to give assistance and transfer them to one of the main emergency departments, in accordance with the department's procedures. The National Early Warning Score (NEWS), a scoring system that identifies patients at risk of deterioration or needing urgent review was used in the unit.
- Staff told us about an incident where a patient had collapsed in Andover War Memorial Hospital and the MIU staff had attended the patient. The MIU staff told us they were instructed by senior staff not to attend such incidents or remove the defibrillator from the department in future. This instruction had not been written down or signed off as a procedure or policy. Three members of staff expressed concern regarding the instruction not to attend such an incident and deliver basic life support. The agreed protocol of the appropriate and safe response to such an incident was not clear to staff. Resuscitation grab bags had been proposed but not yet implemented.
- Staff had access to the mental health crisis team for patients with mental health needs and were supported by a 24 hour advice line.

### Nursing staffing

- The MIU was an emergency nurse practitioner (ENP) led unit. All of the nine ENPs were band 7 grades. Five ENPs were nurse prescribers. Those nurses who were not non-medical prescribers used PGDs to govern the administration of medication.
- The unit had a low vacancy rate, currently there was one vacancy for an ENP.
- The ENPs were supported by clinical nurse assistants (band 2/3 grades), who were also trained to carry out the MIU reception duties.
- Staff sickness was comparatively lower than the rest of the medical division. For example, on average 0% compared to approximately 5% for the trust's main emergency departments (April 2014 to April 2015).
- Staff said that there was an expectation they would cover shifts for colleagues when necessary. Occasionally bank staff were employed to cover shifts.

# Urgent and emergency services

### Major incident awareness and training

- Andover War Memorial Hospital was included in the contingency plan for the trust's response to major incidents.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

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

We rated effective as 'requires improvement'.

A service specification for the MIU included the use of agreed care pathways and compliance with local clinical standards. However, staff did not have access to up to date clinical guidelines and current best practice and standards of care and patient outcomes were not monitored.

Staff were experienced, autonomous practitioners, however, they were not supported to keep their clinical skills up to date through supervision or developmental training.

Patients' pain was appropriately managed. Staff liaised with colleagues at the main emergency departments, and patients were appropriately discharged or transferred to an acute hospital department for their ongoing care and treatment. Patients' records were easily accessed using the trust electronic patient records system.

### Evidence-based care and treatment

- The MIU service specification (dated 1 April 2014 to 31 March 2015) stated 'care is to be delivered according to locally developed and agreed minor injuries protocols and care pathways and is to be regularly reviewed and updated to reflect the latest guidance and best practice'.
- Patients were at risk of receiving care and treatment that was not in line with current guidance as nurses did not have easy access to clinical pathways and protocols. Four emergency nurse practitioners (ENPs) reported there were no clinical guidelines in place for the management of common clinical conditions.
- We found an absence of protocols and clinical guidelines pertaining to best practice, so we could not ascertain if patients were receiving care and treatment that was evidence based.
- The lead ENP for the MIU confirmed that ENPs did not have clinical guidelines to work within and relied on their experience in performing their roles.
- There was no evidence of local audits being undertaken to ensure evidence based care and treatment was being delivered.
- Best practice from the trust's main emergency departments was not shared with the MIU.

### Pain relief

- Nurses administered pain relief through Patient Group Directions (PGDs) unless they held an independent prescriber qualification.

### Patient outcomes

- The MIU saw 17, 425 patients (between 1 April 2014 to 31 March 2015) 498 (3%) were transferred to an acute provider for their ongoing care. The latest figures were similar: of the 4799 patients seen (1 April 2015 and 30 June 2015) 118 (3%) patients were transferred to another hospital, with two thirds, being transferred to the Royal Hampshire County Hospital for care and treatment.
- There was no evidence of regular monitoring of outcomes for patients attending MIU other than patient satisfaction through the friends and family test (FFT) survey. There was no evidence of a high number of complaints or incidents which could indicate concerns with patient outcomes.

### Competent staff

- The information from the trust reported a 38% appraisal rate for April 2014 to April 2015. However the MIU lead nurse stated that five staff had now had an appraisal (83%) at the time of the inspection. Three staff had appraisals pending.

# Urgent and emergency services

- All three ENPs we spoke with told us they were experienced and worked autonomously, but were not supported through clinical supervision. One student nurse said she was supported in her placement and her practice was supervised.
- ENPs told us there had been a cardiac arrest of a patient at Andover hospital (not MIU) in the previous year. The ENP had responded appropriately and resuscitated the patient who was later transferred to the acute trust by ambulance. Once at the hospital, they received further treatment and made a recovery. This demonstrated competent and prompt assessment and response by the MIU ENP.
- Clinical nursing assistants were positive about working in MIU and had received appropriate training to do their job competently. They had extended their skills by learning to do ECG's, wound dressings and application of plaster casts.
- The MIU staff did not rotate to the trust's main emergency departments to maintain their acute clinical skills. However, the service specification noted that nurse prescribers and emergency nurse practitioners 'should undertake training and development in A&E to ensure that their skills are kept up to date.' The trust had recently developed the education faculty to support ENPs across the trust and standardise their clinical practice.

**Multidisciplinary working**

- Nurses referred patients with medical needs to their GP or the out of hours service.
- Nurses had phone access to the emergency department consultants and nurse practitioners, for prompt advice.
- MIU nurse practitioners referred patients to specialist teams in the trust, if appropriate.
- Staff described effective working relationships with social services in relation to raising safeguarding concerns.

**Seven-day services**

- The MIU was open 8.30am to 9.30pm daily seven days a week.
- ENPs were able to request X-rays Monday to Friday, 9am to 5pm which were reported within two working days. Staff reported there were a high number of repeat attenders to the MIU on Monday mornings because there was no radiology at the weekend.
- One of the ENP's reported the outpatient fracture clinic follow-up was not located at Andover War Memorial Hospital. This could be potentially inconvenient to those patients who were required to travel further to the acute hospitals for follow-up appointments.
- There is no pharmacy department at Andover War Memorial Hospital. They do have a clinical pharmacy service, and a pharmacy technician visits three times a week and a pharmacist one day a week.

**Access to information**

- Patients' records were easily accessed using the trust electronic patient records system.
- All paper patient records generated during an episode of care were scanned onto an electronic record when the patient was discharged or transferred out of the department. A secure shredding service was used to ensure patient information was kept safe. This meant there was immediate access to records for any patients re-attending the MIU.
- The Joint Children's Protection Register (a system for checking if children have been at risk of abuse) was available for checking within the department. This system allowed any other agencies involved in the protection of the child to be notified if they attended the emergency department.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We saw patients who were appropriately asked for their consent to treatment.
- Nursing staff had an appropriate knowledge of the Mental Capacity Act and its impact on their practice.

## Are urgent and emergency services caring?

Good

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

We rated caring as 'good'.

Staff provided compassionate care and ensured that patients were treated with dignity and respect. We

observed that patient's privacy and dignity were maintained at all times. One patient we spoke with was very satisfied with the care they had received. We observed caring and sensitive interactions between staff and patients.

The results of the NHS Friends and Family Test (FFT) showed that a higher than average number of patients would recommend the department, although based on a low response rate.

Patients were fully involved in their assessment and treatment.

**Compassionate care**

- The MIU reception desk was located to provide open access but also allowed for a degree of patient confidentiality when patients were providing their personal information.
- We observed caring and compassionate interactions between staff and patients. For example, we observed staff knocking on doors before entering treatment rooms and privacy curtains were drawn to maintain patient's privacy and dignity.
- We spoke with one patient who had previously used the service. They told us they were very satisfied with the care they received on both occasions.
- The NHS Friends and family test (FFT) results (April and May 2015) were 93% and 98%; higher than the England average of 88%. However, this was based on a low response rates of 2% (April) and 7% (May) compared to the England average of 14%.

**Understanding and involvement of patients and those close to them**

- We observed consultations and saw that patients were fully involved in their assessment and treatment process.
- Care and treatment was planned around the individual and their needs and wishes were taken into account.

**Emotional support**

- We heard sensitive and caring conversations between staff and patients.

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

Good

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

We rated responsive as 'good'.

The MIU service planned to meet the needs of patients suffering a minor injury, registered with a local GP. All patients attending the MIU were seen within the national emergency access target of four hours. There was support for patient who had mental health needs.

The MIU was purpose built with sufficient seating and three treatment rooms including one designed for children. A wide range of patient information leaflets were available on common injuries and conditions to support patients.

Complaints information was easily accessible to patients and complaints to the service were low in number and been handled appropriately.

**Service planning and delivery to meet the needs of local people**

- The MIU service specification (dated 1 April 2014 to 31 March 2015) planned to meet the needs of patients, presenting with a minor injury, who were registered with a GP within West Hampshire Clinical Commissioning Group.
- The MIU saw 17,425 patients between 1 April 2014 to 31 March 2015, and 4,799 patients between 1 April 2015 to 30 June 2015. Trend data was not available to identify changes in demand for the service.

**Meeting people's individual needs**

- The waiting room had sufficient suitable seating for patients and relatives.
- MIU treatment rooms had doors or curtains to maintain privacy and dignity when patients were being treated.
- The MIU had a children's treatment room with age appropriate décor, toys and murals.

# Urgent and emergency services

- A range of written information leaflets, for example, head injury, bites and sprains, were available for nurses to provide to patients. We observed a leaflet being handed to a patient following a consultation.
- Staff said they did not have access to translation services by phone; they used the computer if necessary.
- Staff had access to the mental health crisis team for patients with mental health needs and were supported by a 24 hour advice line.

**Access and flow**

- **Patients had timely access to initial assessment, diagnosis and treatment by ENPs. The MIU met their access target of seeing patients within four hours consistently every month including June 2015.**

**Learning from complaints and concerns**

- **Staff were aware of how to handle complaints and advised patients according to the trust's complaints procedures.**
- **The trust leaflets on making complaints and comments were available for patients in the waiting area.**
- **From 1 April 2014 to 31 March 2015 the MIU received two formal complaints. Both had been resolved, learning shared and a personal apology sent to the patients involved, from the chief executive.**

## Are urgent and emergency services well-led?

Requires improvement

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

**We rated well-led as ''requires improvement.''**

**The governance processes to assess and monitor the quality of the service were not effective. The service and clinical standards were not monitored, and risks were not appropriately identified and actioned.**

**The MIU had a small close-working team but they told us they 'Did not feel part of the (wider) trust'. There was a clear lack of consultant supervision of the unit. There was a disconnect between the operation of the unit, and the senior governance processes in the trust.**

**Staff did not feel their concerns were managed effectively and this had recently impacted on staff morale. The trust had recently recognised the issues within the MIU service, and was trying to resolve the situation through a review of the nursing leadership within the department.**

**The culture in the MIU was not conducive to encourage learning and improvement. However, staff were committed to providing a valuable service. They described good team working and a supportive team culture. The NHS Friends and Family test scores were comparatively high, although based on low response rates.**

**Staff described the chief executive as accessible and approachable through her monthly visits to the hospital.**

**Vision and strategy for this service**

- **The service specification for the MIU (dated 1 April 2014 to 31 March 2015) aimed to contribute to reducing waiting times in the emergency departments (ED) by providing the local community with easy access to a high quality service for patients who have suffered a minor injury.**
- **Staff confirmed the purpose of the unit and they felt they provided a valuable service to patients in need of urgent care.**
- **There was no overall strategy for the MIU.**

**Governance, risk management and quality measurement**

- **The service specification referred to 'the MIU will be expected to demonstrate that robust clinical governance arrangements have been established.'**

and 'The MIU will be expected to identify a clinical lead for clinical standards. Their role will be to ensure that clinical standards are being adhered to and to liaise on an ongoing basis with the clinical lead for the emergency department (ED). The unit's staff could not all demonstrate that robust clinical governance arrangements were in place.

- Staff meetings took place and we saw the notes of a recent meeting which discussed operational issues. However, clinical governance issues were not identified and discussed.
- Staff said they were not aware of which consultant had oversight of the unit. Following the inspection, the trust reported there was a named consultant for the MIU who carried out intermittent visits.
- There was not a clear system for monitoring the service or clinical standard. There was no evidence of clinical or internal audit to monitor quality.
- Following the inspection, a risk regarding the lack of on-site security was added to the department risk register on 12 August 2015. Staff told us a risk regarding hypodermic needles that had been raised in 2012 was on the risk register. However, there was no risk related to this on the medical services unscheduled care risk register, and no other risks relating to the MIU on the risk register.

Leadership of service

- The MIU service specification referred to 'substantial supervision arrangements in place in order to manage and assess those people who self-present with significant health problems' and 'the service would be expected to have regular weekly consultant supervision'. However, we found that consultant visits did not happen frequently.
- Staff said they were not aware of the consultant who had senior clinical leadership of the service and no consultant regularly visited the unit to provide oversight or clinical supervision. Following the inspection the trust said there was a named consultant for the unit who carried out intermittent visits.
- Staff were concerned about the clinical leadership of the unit and identified that their concerns were not listened to and their clinical skills were not formally assessed or being supported for development.

Culture within the service

- The ENPs were experienced and autonomous practitioners. Staff in the MIUs said they gained a lot of job satisfaction and described working in a supportive team culture. Many had been long serving in the unit. However, they felt recent management changes had adversely affected their morale. The leadership of the service was identified as unsupportive and actions taken to address concerns had not been effective.
- Staff said they felt 'separate from the rest of the trust.'
- Senior nursing management had been made aware of leadership issues within the MIU service and was trying to resolve the situation. This included a review of the nursing leadership within the department and the potential future appointment of a senior nurse (Band 8a) to oversee the service.

Public engagement

- The unit used the NHS Friends and Family test to monitor patient satisfaction and not have any other forms of patient engagement.

Staff engagement

- The MIU had a small number of staff accommodated in the same room, this facilitated daily communication and information sharing.
- Staff told us that morale was currently low. Staff told us they felt able to raise concerns but were not confident their concerns would be investigated appropriately at unit or trust level.
- Staff told us the chief executive visited Andover War Memorial Hospital monthly for an open meeting with staff and a representative from the MIU usually attended.
- Staff told us that senior nursing management from the acute hospital were not visible at the MIU.

Innovation, improvement and sustainability

- We did not see any evidence of quality improvement projects or changes in practice to improve the service.

# Medical care (including older people's care)

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Andover War Memorial Hospital (AWMH) is part of Hampshire Hospitals NHS Foundation Trust. The hospital provides medical services at a rehabilitation unit which is a 22 bedded ward (Kingfisher ward).The Kingfisher ward provides rehabilitation for a variety of medical, care of elderly and post-surgical patients but for the purposes of reporting has been included within the medical services inspection report.

We spoke with approximately 14 patients, including their family members, seven staff members including clinical leads, service managers and matrons, ward staff, therapists, junior doctors and , and other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records and attended handovers. We reviewed documentation from stakeholders and performance information from the trust.

## Summary of findings

We found that medical care (including older people's care) was 'good' for safe, effective, caring, responsive and well led services.

Process and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents and the learning from incidents was used to improve the service. The ward environment was clean and equipment was available and well maintained. Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm free care. Safeguarding protocols were in place and staff were familiar with these. Nursing staffing levels were appropriate; junior doctors were present during weekdays and there were arrangements for on call medical cover at the weekend.

There were appropriate procedures to provide effective care. Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines.

Patients were cared for by a multidisciplinary team working in a coordinated way and staff had good access to training. There were effective arrangements to ensure that staff had the necessary skills and competency to care for patients; staff had good access to training and professional development opportunities. When patients

lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements. However, the capacity assessments were not always documented in patient care records.

Patients received compassionate care from staff that respected their privacy and dignity. Patients told us they felt involved in decision making about their care. We found staff were caring and compassionate. Patients we spoke with praised staff for their empathy, kindness and caring. There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.

Patients were not waiting for access to rehabilitation to Kingfisher ward and once admitted rehabilitation was commenced immediately with active therapy input. Patients who were medically declared fit and needing further rehabilitation input were transferred from RHCH and BNHH to Kingfisher ward. Occasionally patients were also admitted from other acute NHS trust hospitals in the locality or referred by GPs. Patients regularly received medical input and were regularly seen by the therapists who assisted the patients to work towards their rehabilitation goals. The ward based social worker supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS funded continuing care.

The data provided by the trust demonstrated, there were an increasing number of delayed transfers of care (January 2015 to May 2015). We were told by the social worker and nursing staff on the ward that the main cause of delays was the provision of community services, especially care home placement, to meet patients' on-going needs.

The medical services had a long-term strategy and priorities around improving the services this included improving the pathway for frail elderly patients. There was not however, specific plans for the development of the service in Andover. There were effective governance arrangements and staff felt supported by service and trust management. Lessons from incidents and complaints were usually shared within the staff.

The culture on the Kingfisher ward was caring and supportive. Staff were actively engaged and innovation and learning was supported. There was good local leadership at ward level. The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service.

# Medical care (including older people's care)

## Are medical care services safe?

Good

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

We rated safe as 'good'.

Process and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents. Themes from incidents were discussed at ward meetings. Although nursing staff were not aware of the requirements of the Duty of Candour legislation they described an ethos of openness and transparency in responding to incidents.

The environment and equipment were well maintained and, equipment was regularly checked to ensure it continued to be safe to use. Staff had access to necessary equipment needed for pressure area care. Infection control practices were followed appropriately. Infection rates for MRSA and C.difficile in the trust were low compared to other similar trusts. Medicines, including controlled drugs, were appropriately managed. Patient records included person centred information and were appropriately completed. Patients were appropriately escalated if their condition deteriorated and action was taken to ensure harm free care.

Nurse staffing levels were appropriate and medical cover was provided by junior doctors on weekdays. The junior doctors told us they were well supported by senior medical staff. On-call medical cover was available from Royal Hampshire County Hospital in Winchester outside of these hours and over the weekend.

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

### Incidents

- The medical services for the trust, of which the Kingfisher ward was a part, reported 44 serious incidents through the National Reporting and Learning System for the period May 2014 to April 2015. Of these incidents, grade three and four pressure ulcers and slips, trips or falls accounted for the highest number of incidents.
- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. They were able to give us examples of range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls. Staff stated they were encouraged to report incidents.
- Staff told us they received feedback on the incidents they had reported. Minutes of monthly ward meetings confirmed that the themes of incidents were fed back to staff.
- Themes from incidents were discussed at ward meetings and staff were able to give examples of where practice had changed as a result of incident reporting.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, in response to high number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification of falls by using falls risk assessments and developing comprehensive action plans. Throughout our inspection we observed that the patients at high risks of falls were clearly identified and actions to minimise the risk were taken. For example non-slip socks and low level beds were used on the ward. Patients' relatives were also encouraged to bring the most suitable footwear for the patients and educational advice for patients and relatives on various aspects for falls were displayed in ward areas. The ward had a falls champion in post who had conducted scenario training on falls for all the ward staff.
- The learning from incidents was also shared across the trust via the route of the trust's monthly bulletin and staff newsletter.
- Medical services held mortality and morbidity meetings on a monthly basis. The senior nursing staff such as matron on the Kingfisher ward attended these meetings at the Royal Hampshire County Hospital (RHCH). Records of the mortality and morbidity meetings minutes showed that any death that had occurred in the department was reviewed, the root causes analyses following incidents were discussed, and any lessons to be learnt were shared.

- Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a severe or moderate level of harm.
- Nursing staff we spoke with were unfamiliar with the requirements of the Duty of Candour legislation. However, all staff who we spoke with understood the principles of openness and transparency that are encompassed by the Duty of Candour. Staff were aware of the importance of investigating incidents and potential mistakes but were not aware that the Duty of Candour now made meeting the patient/family and sharing the findings of investigations a legal requirement.

**Safety thermometer**

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls.
- The ward had information displayed at the entrance about the quality of the service and this included Safety Thermometer results. There was information about infection control measures, results of NHS Friends and Family Tests, numbers of complaints, levels of staff absenteeism, mandatory training update, and numbers of patient falls, new pressure ulcers, new catheter related urinary tract infections and new venous thromboembolisms (blood clots). This information was presented in a format that could be easily understood by the general public.
- Between July 2014 and June 2015 (for medical services of which the Kingfisher ward was a part) there had not been a consistent reduction in the prevalence rate of new pressure ulcers with periods of both reductions and then periods of increase. Between July 2014 and June 2015, the trust had similar or less number of falls than the national average in most of the months except for May 2015 where the number of falls were above national average.
- The medical division performance and finance report (July 2014 – June 2015) identified that the number of falls was higher than expected (123) although falls with moderate, severe harm or death was within expected numbers (overall 3 per month). The figures for falls with harm had increased in February and March 2015. The number of hospital acquired grade 2, 3 or 4 pressure sores was overall three to four times higher per month than the expected target of 5 per month. The VTE risk assessment for 95% of patient was being achieved.
- In response to high number of incidents related to pressure ulcers, the trust had conducted pressure ulcer awareness training for staff. Pressure ulcer care bundle and risk assessments were developed and access to a tissue viability nurses was made easier. The Kingfisher ward had a 'pressure ulcer' resource folder which had updated information on management and suggested action plan for pressure ulcers.

**Cleanliness, infection control and hygiene**

- The Kingfisher Ward area was visibly clean and cleaning schedules were clearly displayed on the ward.
- Hand hygiene gel was available at the entrance to ward, along corridors, and at the bottom of each patient's bed.
- We observed staff compliance with hand hygiene, isolation procedures and the correct use of personal protective equipment (PPE), such as gloves and aprons. Staff adhered to the trust's 'bare below the elbows' policy in clinical areas.
- There were isolation procedures and protocols around the use of side rooms or cohort bays and we observed these being used appropriately.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinical environment.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection in the hospital. The percentages of staff who had completed the infection control training varied across the medical services. The data provided by the trust demonstrated that between 76% to 100% of staff on Kingfisher ward had completed the training as of June 2015.
- Equipment was cleaned, but was not marked as ready for use, except for the commodes which were marked with 'I am clean' stickers. Clean and dirty equipment were not segregated appropriately and staff lacked knowledge about assurance process for distinguishing between clean and dirty equipment.
- Standards of cleanliness were monitored. The Kingfisher ward participated in the monthly infection control audits. There was an action plan to address where improvements were identified. For example the

compliance for hand hygiene procedures was identified as low in infection control audit completed in April 2015. There was an action plan to address this concern and plans to follow up on this in the next audit cycle.
- The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and for Clostridium difficile were lower when compared to trusts of similar size and complexity.

**Environment and equipment**

- We observed elements of dementia friendly design was incorporated into the care of the ward areas, for example colour coding system was used for different bays and pictorial signage being used.
- The ward had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due.
- Resuscitation equipment was available on the ward and this was maintained and regularly serviced. However, we found random gaps in the daily checks of the resuscitation equipment in the month of July 2015.
- Equipment such as commodes, bedpans and urinals were readily available on the ward.
- Ward staff told us they had good access to equipment needed for pressure area care. Equipment was ordered using an electronic system and was delivered from the central equipment store at Basingstoke and North Hampshire Hospital (BNHH).The ward had its own storage of equipment such as walking frames and moving and handling equipment.

**Medicines**

- Medicines were stored correctly, including in locked cupboards or fridges when necessary. Checks on the temperature of medicines fridges were completed daily.
- Controlled drugs were managed and stored appropriately. Patients' medication charts clearly identified any known allergies to reduce the risk of being given inappropriate medication.
- There was a good system of electronic prescribing across the trust. Staff we spoke with told us the support from pharmacy service was good.
- Ward sisters were aware of medicine incidents which happened on their wards and the learning they took from these incidents.
- Patients told us they were usually given their medicines on time. They also said medicines were explained to them and they were told about risks associated with taking medication.
- We observed staff giving patients medication only after correct checks were made. Nurses undertaking drug rounds were protected from interruptions. Staff had good access to information about medicines.
- The trust antimicrobial prescribing policy was being adhered.

**Records**

- The trust had recently introduced new patient care records for nursing staff. The new records were in paper format and included various risk assessments, including, venous thromboembolism (VTE), falls, malnutrition and pressure ulcers. Nursing staff told us that the new care records promoted more patient centred care and found them beneficial.
- The introduction of new paper records for nurses meant that different notes were held by healthcare professionals. For example, medical and nursing staff documented in separate set of patient records. The trust was aware of this and had plans to introduce a combined set of patients' records.
- We reviewed eight patient care records on the ward. Patient records were well maintained and completed with clear dates, times and designation of the person documenting. The records we reviewed were written legibly and assessments were comprehensive and complete, with associated action plans and dates.
- The admission notes were legibly documented by medical staff in keeping with general medical council (GMC) guidance which included recording patient concern, details of any actions taken, information shared and decisions made relating to those concerns.
- The appropriate risk assessments were completed for patients at risk of pressure ulcers or falls.
- The medical records of these patients demonstrated that they were reviewed regularly by medical staff.

# Medical care (including older people's care)

**Safeguarding**

- All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns. Staff were able to explain the types of concerns which would result in a safeguarding alert being raised.
- The ward had allocated a safeguarding lead who staff could access for support and, although not all staff we spoke with were aware of this.
- Staff told us they had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy. The data provided by the trust demonstrated approximately 87% of the staff on the Kingfisher Ward had completed adult safeguarding training as of June 2015.This was against the trust's target of 85%.
- Staff told us safeguarding concerns were reported as incidents and any concerns would be discussed in handover meetings and shared across the team.

**Mandatory training**

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, conflict resolution, consent and information governance training. Staff told us they were up to date with their mandatory training. Staff received an electronic reminder when the training was due.
- The data provided by the trust showed us that the compliance with mandatory training varied across different disciplines. The range of staff compliance varied between 68% to 100%. However, most staff achieved 80% to 100% compliance against the trust's target of 80%.
- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.

**Assessing and responding to patient risk**

- Risk assessments were undertaken for individual patients in relation to venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the risks identified.
- There were clear strategies for minimising the risk of patient falls on the Kingfisher ward. Staff on the ward demonstrated a good understanding of the causes of falls and how to avoid them.
- Patients admitted to Kingfisher ward were generally medically stable and fit and had rehabilitation needs. The ward was led by nurses and medical cover was available between Monday to Friday by Foundation year 2 (FY 2) doctors. Nursing handovers occurred at every shift change, during which staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients.
- The National Early Warning Score (NEWS), a scoring system that identifies patients at risk of deterioration or needing urgent review was used on the ward. Nursing staff were aware of the appropriate action to be taken if a patient scored higher than expected. This included contacting emergency ambulance service if a patients' condition suddenly deteriorated. The ward staff told us that this situation did not happen routinely and they could contact the medical on call team at RHCH for medical advice.

**Nursing staffing**

- Nursing numbers were assessed using the acuity tool and there were identified minimum staffing levels. The safe staffing levels were displayed at the entrance of the ward, including planned and actual numbers.
- The nursing staff told us the staffing levels were adequate and the ward was established with full staffing capacity.
- We reviewed the nursing rota for the months of June and July 2015 and found that planned staffing levels were met for the majority of shifts. Bank staff were employed to cover shortfalls in staffing if required.
- Staff we spoke to felt supported by senior nurses and matrons and did not express any concerns around staffing numbers.
- Patients told us the staff and the ward was busy but the nursing staff looked after them and they did not have to wait long for help or care.

**Medical staffing**

- The Kingfisher ward was mainly led by nurses and medical cover was available from Foundation year 2 doctors from Monday – Friday between 9am to 5pm.

# Medical care (including older people's care)

- On call medical cover was available from RHCH outside these hours and over the weekend.
- If a patient's condition deteriorated they were usually transferred to RHCH by ambulance.
- The junior doctor on the ward we spoke to felt well supported by a consultant at RHCH and could contact them for medical advice or support.

**Major incident awareness and training**

- Staff we spoke to were aware of the procedure for managing major incidents, winter pressures on bed capacity and fire safety incidents.
- Emergency plans and evacuation procedures were in place. Staff were trained in how to respond to major incidents.

## Are medical care services effective?

Good

**By effective, we mean that people's care, treatment and support achieves good outcomes,**

**promotes a good quality of life and is based on the best available evidence.**

We rated effective as 'good'.

Staff provided care to patients based on national guidance, such as National Institute for Clinical

Excellence (NICE) guidelines. Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports. The unit did not participate in the medical services clinical audit programme to monitor clinical standards. The ward participated in local audits such as environmental audits, infection control audits and audit related to readmission to an acute hospital from a rehabilitation ward. The service had developed action plans in response to these audit outcomes and these were being implemented and monitored.

Patients' pain and response to pain relief was appropriately monitored and patients were given pain relief when needed. Patients at risk of malnutrition or dehydration were risk-assessed appropriately, and referred to a dietician for specialist care when required.

Staff received training and this included training to support people living with dementia. Staff had access to specialist training courses and had appropriate supervision and appraisals. Staff worked in multidisciplinary teams to coordinate patient care.

Staff told us they had good access to patient-related information and records when required

Patients were consented appropriately and correctly. Most staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, we found that the capacity assessments were not always documented or regularly reviewed in patients' care records.

Seven day services were underdeveloped and medical and therapy staff only worked Monday to Friday.

**Evidence-based care and treatment**

- Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines. We saw evidence of discussion on NICE guidelines such as the pressure ulcer prevention and management guideline and assessment and prevention of falls in older people guideline in patients' health care records. The staff were aware of recent changes in national guidance.
- Policies were accessible for staff and were developed in line with national guidelines, such as the pressure ulcer prevention and management policy. Staff we spoke with were aware of these policies. Patient records we reviewed showed risk assessments and care plans for patients who were at risk of developing pressure ulcers.
- There were integrated care pathways based on NICE guidance for patients with heart failure, long term respiratory conditions and for the rehabilitation of patients who had hip surgery following fracture neck of femur (hip fracture).
- The data provided by the trust demonstrated that the unit did not participate in the medical services clinical audit programme. Therefore clinical service standards were not being monitored.
- The ward participated in a few local audits such as environmental audits, infection control audits and audit related to readmission to an acute hospital from a rehabilitation ward. The service had developed action plans in response to these audit outcomes and these were being implemented and monitored.

# Medical care (including older people's care)

**Pain relief**

- We observed nurses monitoring the pain levels of patients and recording the information. Pain levels were scored using the National Early Warning Score (NEWS) chart.
- For patients who had a cognitive impairment, such as dementia or a learning difficulty, staff used the 'Abbey Pain Scale' to aid their assessment. This scale was developed for patients with communication difficulties who were unable to verbalise how much pain relief they required.
- Staff had good knowledge of pain management. The information was appropriately recorded in patients' records. We reviewed eight nursing records for patients where pain assessments were recorded. Records demonstrated patient's needs were being discussed and met.
- Patients we spoke with told us they were given pain relief when they needed it and nursing staff always checked if it had been effective.
- There was a Patient Group Directive for nursing staff to prescribe pain relief and this was being used appropriately.

**Nutrition and hydration**

- Patients' nutrition and hydration status was assessed and recorded on all the medical wards. We observed that fluid balance charts were used to monitor patients' hydration status informing clinical decisions.
- The Malnutrition Universal Screening Tool (MUST) was used in all the wards and medical units. Patients who were nutritionally at risk were referred to a dietician.
- A colour-coded tray system was used on all medical and care of elderly wards and units to identify patients who needed help with eating and drinking. We observed this on Kingfisher ward. All patients had access to drinks which were within their reach. Care support staff checked that regular drinks were taken.
- We observed that nursing staff provided assistance to patients who needed support with their meals. Relatives and carers were encouraged to assist patients at meal time.
- Patients told us they were always given choices for food and snack menu. Patients were highly complimentary about the quality of food provided.

**Patient outcomes**

- **The mortality rates for Kingfisher ward were within the expected range.**
- **The Kingfisher ward did not contribute to any national audits they did not meet the eligibility criteria for participation for national audits.**
- **Standardised readmission rates compared favourably with national rates (January 2014 to December 2014), except for geriatric medicine which were significantly above national rates.**
- **Patients received intensive therapy input working towards their rehabilitation goals aiming to reach maximum level of independence that was achievable before they returned home. Patients told us that the therapists assisted them to work towards rehabilitation goals and promoted independence. Relatives and carers of patients told us that Kingfisher was a great resource for elderly patients living in local community.**
- **Patient outcomes were monitored in the Kingfisher ward and information about these outcomes was included in the trust's clinical governance reports. Included in this report was a review of incidents, complaints, general patient safety information, infection control review, sharing from incidents and information. This information was also shared with the ward staff.**

**Competent staff**

- **There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.**
- **Trust data for nursing and clinical staff demonstrated appraisal rates in the medical division, for which Andover War Memorial Hospital is part of, was between 67% to 78%. This was lower than trust targets of 80%. However, staff on Kingfisher wards all told us**
- **Nursing and therapy staff told us they received formal supervision although we did not see formal written evidence or data on this.**
- **Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example the ward conducted a comprehensive weekly training programme for**

staff to improve the awareness and quality of care delivered by clinical staff at the hospital. The range of topics covered in the training programme included catheterisation, dysphagia, falls awareness and health coaching. Staff told us they attended the training and found it beneficial.

- The Kingfisher ward had regular input from a dementia specialist nurse. Most staff on the ward had attended dementia training. A selected number of staff were trained to become dementia champions to support and share practices.
- The ward had a practice educator who supported newly qualified nurses to develop confidence in their clinical skills. The practice educator also offered support to nursing staff following any performance related issues.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors rated their overall satisfaction with training as similar to other trusts.
- Junior doctors we spoke with said they were well supported and they felt hospital was a good place to work.
- The therapy staff on the medical wards told us that they attended in-service training once a week which was held at RHCH, and the junior physiotherapy staff also received weekly teaching related to their speciality.

**Multidisciplinary working**

- Staff felt that integration across the three sites of the trust had improved. This had allowed for improved coordination between medical services and better management of patient care and treatment. Therapy and nursing staff, for example, told us they were better able to consult the medical consultants or nursing and therapy staff from the referring ward at BNHH or RHCH to discuss patient related information.
- Staff told us that multidisciplinary team (MDT) working across the hospital was good. Junior doctors and nursing staff told us nurses and doctors worked well. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- There was evidence of multidisciplinary working on the Kingfisher rehabilitation unit which included nurses, physiotherapists, dieticians, occupational therapists, doctors and social workers. Multidisciplinary team board rounds took place in the ward every morning when plans relating to appropriate discharge and reviews of unwell patients were discussed.
- Multidisciplinary team meetings took place once a week to discuss current and new patients. Staff told us this meeting was attended by various health professionals such as nurses, doctors, physiotherapist, occupational therapist and social workers.
- The social worker arranged case conferences to assist with complex discharges. The case conference was usually attended by social worker, nursing and therapy staff, patient and their carers and occasionally by a representative from community teams from Southern Health Foundation NHS Trust.

**Seven-day services**

- The Kingfisher ward had therapy cover from Monday-Friday between 8am to 5pm.There was no therapy cover provided over the weekend. The patients who were admitted or transferred to the ward over the weekends were assessed by therapists on the following Monday.
- The Kingfisher ward was mainly led by nurses and medical cover was available from junior doctors (Foundation year 2) Monday – Friday between 9am to 5pm. On-call medical cover was available from RHCH outside these hours and over the weekend.
- There is no pharmacy department at Andover War Memorial Hospital. They do have a clinical pharmacy service and a pharmacy technician visits three times a week and a pharmacist one day a week.
- Chaplaincy services were available and covered all three hospital sites, 10am to 6pm Monday to Friday with on-call cover out of hours.

**Access to information**

- Staff told us they had good access to patient-related information and records whenever required. The bank staff also had access to the

information in care records to enable them to care for patients appropriately. All areas used electronic handover sheets to ensure all staff had up-to-date information about patients on the ward.

- There was a patient transfer summary in patients' notes for those who were transferred from RHCH and BNHH. The transfer summaries that we reviewed in patients' notes were completed appropriately. This ensured that the transfer information was shared and the patient care continued with minimal interruption and risk.
- Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received. Ward staff told us these were always sent within 48 hours following patient discharges. This ensured that GPs were aware about their patient's discharge and could offer adequate community support if required.
- The ward had resource folders available for staff on dementia, falls, safeguarding and tissue viability which had information on relevant guidelines and support networks in the community. Staff told us they found the resource folders a useful bank of knowledge. The relevant clinical guidance was also available on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs). Staff were able to seek advice and extra training on MCA and DOLs if that was required.
- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding treatment and care patients required. This was particularly observed for the patients who had been diagnosed as living with dementia.
- We found that the capacity assessments were not always documented in patient care records. At the time of our inspection there were three patients on the ward that had Deprivation of Liberty Safeguards (DoLS) in place. We reviewed the care records of these patients and found that the processes for application for DoLS were followed and the DoLS authorisations were in date. However, there was no documentation regarding the assessment of mental capacity in any of their care records. This meant that staff had not followed the principles of MCA and were not able to justify whether the decision was made in patients' best interest where they lacked the mental capacity.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Staff were aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority instigate a DoLS to temporarily deprive a patient of their liberty.

## Are medical care services caring?

Good

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

We rated caring as 'good'.

Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback

from patients and their relatives was consistently positive about the way staff treated them and their feedback strongly evidenced there was a caring and supportive culture in the

Kingfisher ward. The results of national patient surveys showed patient satisfaction was similar to other trusts.

Patients and relatives we spoke with said they were well informed and involved in the decision making process regarding their treatment. The trust encouraged carers and relatives of patients living with dementia to stay with their loved ones while he or she was an inpatient on the ward by offering them a carer's passport.

# Medical care (including older people's care)

**Understanding patient's emotional needs was highly valued by staff, and this was embedded in their care and treatment. During our inspection we observed that staff were responsive to patients' needs, and we witnessed multiple episodes of kindness from motivated staff towards patients on their ward.**

**Compassionate care**

- **The results of the NHS Friends and Family Test were displayed on the Kingfisher ward. There were posters encouraging patients to give their feedback so that the care provided could be improved. Overall the results showed high levels of satisfaction with the service provided (April 2014 to February 2015) with a score of 99 out of 100 where patients were 'extremely likely' to recommend the service. The average trust score for medical services overall was almost similar to the England average.**
- **The CQC Inpatient Survey (2014) found the trust scored similar to other trusts on all the indicators.**
- **The Cancer Patient Experience Survey (2013/14) found the trust scored similar to other trusts on 33 out of 34 indicators and better than the other trusts for the remaining one indicator.**
- **We spoke with 14 patients and relatives of patients on the ward. All patients we spoke with said that staff provided a good and caring service.**
- **We found the care and treatment of patients on the ward was empathetic and compassionate and staff had developed trusting relationships with patients and their relatives.**
- **Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed multiple examples where staff demonstrated compassionate and kind care.**
- **We observed staff communicating with patients in a respectful way in all situations. Staff ensured confidentiality was maintained when attending to care needs. We observed that call bells were answered in a timely manner on most occasions.**
- **Patients were positive about the care and treatment they received. For example, a patient told us "the nurses are compassionate and lovely and they feel safe". A patient's relative told us "The care is absolutely brilliant and nurses are sensible, kind and caring."**

**Understanding and involvement of patients and those close to them**

- **Patients and relatives we spoke with stated that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care and felt involved in the decision-making process regarding their treatment.**
- **Relatives felt they were fully informed about their family member's treatment and care most of the time. We were told by three relatives that they were not informed about the transfer of their patient from the acute hospital to the Kingfisher ward.**
- **Both patients and their relatives commented that information was discussed in a manner they understood. None of the patients we spoke with had any concerns with regard to the way they had been spoken to, and all were complimentary about the way they were treated.**
- **We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.**
- **Patients told us that they had been involved in developing their care plan and goal planning and understood what was in place for the future management of their care. One patient told us 'my family was involved in developing my care plan and my son helps me with most of the care'.**
- **The trust had introduced a carer's passport which the carer could request from the nurse in charge of the ward. This was to encourage carers and relatives of patients living with dementia to stay with their loved ones while he or she was an inpatient on the ward. The carers were encouraged to provide care for their loved one, such as help with eating meals or personal care. We spoke with the relatives of patients who found this was a good initiative and beneficial for both themselves and patients. We were given an example where a**

patient's relative who was also their main carer was encouraged to visit the patient outside the ward opening hours and was encouraged to help them with meals and personal care tasks.

Emotional support

- During our inspection we observed that staff were responsive to patient's needs, and we witnessed on several occasions patients being treated with kindness from motivated staff.
- Staff told us that the dementia volunteers visited the ward on a frequent basis, and spent time with patients living with dementia. They assisted the patients with various activities such as at meal times, reading a newspaper or generally talking with them.
- The hospital chaplaincy had a visible presence around the hospital and were happy to meet people to offer them support.

## Are medical care services responsive?

Good

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

We rated responsive as 'good'.

Patients who were medically declared fit and needing further rehabilitation input were transferred from RHCH and BNHH to Kingfisher ward. Occasionally patients were also admitted from other acute NHS trust hospitals in the locality or referred by GPs. Patients were not waiting for access to rehabilitation to Kingfisher ward and once admitted rehabilitation was commenced immediately with active therapy input.

Support was available for patients living with dementia and patients with a learning disability. We were given examples of the trust working closely with other local mental health NHS teams to meet the needs of patients in vulnerable circumstances.

Complaints were handled in line with the trust's policy although many were not dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved. Patients we spoke with felt they would know how to complain if they needed to.

Service planning and delivery to meet the needs of local people

- Patients who were medically declared fit and needing further rehabilitation input were transferred from RHCH and BNHH to Kingfisher ward. Occasionally patients were also admitted from other acute NHS trust hospitals in the locality or referred by GPs.
- The 22 bedded Kingfisher rehabilitation ward was designed to provide rehabilitation for people locally living in Andover. A variety of patients including elderly patients living with dementia, those with cardiac problems or recovering from serious infection were admitted to the ward. Patients following post orthopaedic procedure or post general surgery were to this ward to achieve further rehabilitation goals.
- Patients regularly received medical input and were regularly seen by the therapists who assisted the patients to work towards their rehabilitation goals. Occupational therapists carried out environmental risk assessments in patients' home prior to their discharge. Patients were referred to community therapists if they needed further rehabilitation input following their discharge.

Access and flow

- Bed occupancy in the trust was in the range of 73% to 83% (April 2013 to December 2014). This was below the England average of 88%. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.

# Medical care (including older people's care)

- **Patients were not waiting for access to rehabilitation to Kingfisher ward from RHCH and BNHH. Patients had timely transfers and once admitted rehabilitation was commenced immediately with active therapy input.**
- **The average length of stay for patients in the Kingfisher ward was between six to eight weeks. The goal was for rehabilitation for up to six weeks. However, this was being exceeded due to waiting for social care discharge arrangements.**
- **Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. The ward based social worker supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS funded continuing care. Discharge arrangements were discussed at the daily board rounds.**
- **The data provided by the trust demonstrated there were an increasing number of delayed transfers of care (January 2015 to May 2015). We were told by the social worker and nursing staff on the ward that the main cause of delays was the provision of community services, especially care home placement, to meet patients' on-going needs. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.**
- **The ward staff had closer working links with community teams from Southern Health Foundation NHS Trust where patients were referred for further rehabilitation input following their discharge.**

**Meeting people's individual needs**

- **There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.**
- **The trust had introduced a 'this is me' booklet for patients living with dementia, which had been developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. On the Kingfisher ward we saw that patients living with dementia had the booklet and it was appropriately completed. A 'sunflower' symbol was used to identify people living with dementia on the ward.**
- **All patients over 75 years were screened for dementia using a recognised methodology on their admission. The patients living with dementia were assessed by the dementia specialist nurse who visited all the care of elderly wards and also saw referrals on the other medical wards. Staff had completed basic dementia awareness training. The ward had a named dementia champion. The trust had developed a 'dementia care bundle' which assisted staff to meet the needs of these patients.**
- **The trust had improved its performance against the national CQUIN dementia targets for 90% of patients over 75 years to be asked dementia case finding questions, for patients to have a diagnostic assessment and be referred for further diagnostic advice (April 2014 – March 2015). The targets were being met from June 2014, although referrals for further advice was not consistently on target.**
- **There was an arrangement with the local NHS mental health services to provide a liaison service for people with learning disabilities and mental health disorders. For example, staff were able to access support from learning disability nurses, who were employed by Southern Health Foundation NHS Trust on week days for individual patients. The staff were not aware about any 'flagging' or 'alert' system being used when patients with a learning disability were admitted to the hospital. The learning disability nurses relied on the ward's staff or family members for individual referrals.**
- **The trust was supporting carers of patients with mental health problem to stay overnight if that was beneficial to the patients and if it was appropriate.**
- **Interpretation services were available and staff knew how to access the service when needed. Wide range of patients' literature was displayed in clinical area covering diseases. Procedure specific-information, health advice and general information relating to health and social care services available locally.**

# Medical care (including older people's care)

- **The Kingfisher ward had activity coordinators who planned and conducted different activates for patients after consulting them. The activities included a range of things such as arts and craft, music, dance, group lunches and movie time. We observed patients participating and enjoying these activities on care of elderly wards and stroke ward. Staff and patients' relatives told us this had helped in providing a good emotional support, especially to patients living with dementia and made them feel the hospital was a homely environment.**

**Learning from complaints and concerns**

- **The medical services monitored both complaints and concerns. The medical division performance and finance report (July 2014 – June 2015) identified that approximately 43% of complaints had not been responded to within the trust target of 95% within 25 days.**
- **The data provided by the trust for the year July 2014 to June 2015, listed 284 complaints in respect of medical services of which the Kingfisher ward was a part of. The services were trying to improve responsiveness by contacting the complainant soon after the complaint was received. All patients who raised a complaint received a written apology from the chief executive officer (CEO). This created a personal approach to dealing with complaints.**
- **Complaints were handled in line with trust policy; staff showed us that patients were given information on how to complain. Staff directed patients to 'Patient Advisory Liaison Service (PALS)' if they were unable to deal with their concerns directly and advised them to make a formal complaint.**
- **Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint, formally or informally.**
- **Where patient experiences were identified as being poor, action was taken to improve their experiences. Staff told us that any learning from complaint investigations was shared with the team. The trust's monthly newsletter also shared lessons learnt from concerns and complaints across the trust.**

## Are medical care services well-led?

Good

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

**We rated 'well-led' as 'good'.**

**The priorities for the service were to improve patients' journey and treating patients in the most appropriate area and specialism, developing a frailty unit for care of elderly patients and to further improve and expand the dementia care team for better care. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge especially for patients with long term conditions and complex frail elderly patients.**

**There was an effective governance structure to manage risk and quality. Staff felt supported by their managers. There was strong local leadership on the Kingfisher ward. Staff said that the leadership and visibility of managers in medicine was good.**

**Staff were passionate to deliver quality care and an excellent patient experience. The culture was caring and supportive. Staff were actively engaged and there was culture of innovation and learning. Patient feedback was collected and used in planning many of the services we visited. These included patients' survey feedback and learning from complaints.**

**The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service. We saw many examples of innovation and good practice.**

**Vision and strategy for this service**

- **The service leads were clear about their priorities and identified the long term strategy for the medical services for the trust, of which the Kingfisher ward was a part. The medical and care of elderly service leaders' long term strategy for**

medicine was based on the future plans of developing the critical treatment hospital (CTH). The strategy was to provide a highly responsive service that delivers care as close to home as possible by providing medical services seven days a week on the two sites; RHCH and BNHH and at the CTH with access to rapid diagnostics, a senior opinion and inpatient care when required.

- The service leads did not identify a local strategy for medical services at provided at Kingfisher ward, and how this specifically fitted into the trust overall strategy for medical services and care of the elderly.
- The leaders identified the priorities for the service to improve patients' journey and treating patients in the most appropriate area and specialism, developing frailty unit for care of elderly patients and to further improve and expand dementia care team for better care. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge especially for patients with long term conditions and complex frail elderly patients. We found some elements in the strategy that had been or were being implemented. For example, the trust had commissioned external agency to assist in identifying challenges related to the patients' journey and access and flow. The service was also aiming to improve the sustainability of seven day working across the three sites of the trust.
- Staff we spoke with were aware of the strategy and described high quality patients' care as key components of the trust's vision. Managers were able to discuss the strategy and describe the challenges the trust had in its implementation. The staff we spoke to were passionate about improving services for patients and providing a high quality service.

**Governance, risk management and quality measurement**

- The medical services had a robust governance structure that went from ward level to the trust board.
- The medical services across of the trust produced a monthly performance and finance report. It showed how the services performed against quality and performance targets. Members of staff told us that these were discussed at team meetings and there were actions identified for targets that were not met. The ward area had visible information in the form of the quality dashboard.
- The clinical governance team collated data and produced a report for the medical service each month, which was included in the trust's clinical governance reports. The Kingfisher monitored information about patients. Included in this report was a review of incidents, complaints, general patient safety information, infection control review, sharing from incidents and information. This information was shared with the ward staff.
- The medical service had monthly clinical governance meetings where the results from clinical audits, incidents, complaints and patients' feedback were discussed and shared with staff. Minutes of clinical governance meetings showed patients' experience data were also reviewed and monitored.
- The Kingfisher ward had regular team meetings at which performance issues, concerns and complaints were discussed. If staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The service had a risk register that included all known areas of risk identified in the medical service. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated. The higher risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee and risk committee.
- The medical services produced a monthly newsletter which was shared with staff. This included patient stories and lessons learnt.

**Leadership of service**

- The Kingfisher ward had a manager who provided day-to-day leadership to members of staff on the ward. Ward staff felt well supported by their ward manager and matrons and told us they could raise concerns with them.

- **Staff spoke highly about the ward sister and local leadership on the Kingfisher ward. They had confidence in their local leaders, which included matrons, ward managers and lead consultants. Staff told us the matron was visible and had a regular presence on their ward. Staff told us that the Chief Nurse was approachable and helpful.**
- **Staff spoke highly of the chief executive, and said she was accessible to them.**
- **Staff told us the medical service leads had a visible presence on the wards and provided good leadership.**

**Culture within the service**

- **Staff spoke positively and passionately about the care and the service they provided. The ward philosophy included a statement; 'We pride ourselves by doing ordinary things extraordinarily well'. This was embedded in staffs' behaviour and they spoke passionately about their work and of being part of the team.**
- **Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.**
- **Front-line staff worked well together, and there was obvious respect across various disciplines. Staff said they felt valued team members. They provided examples where local management had supported them with their professional and personal development needs to enable them to work to their best ability.**

**Public engagement**

- **There were examples of patients being closely involved in service development. These included patient survey feedback such as the NHS Friends and Family Test and learning from complaints and more proactive work to gather views direct from patients receiving treatment from different community services.**
- **Clinical governance meetings showed patient experience data were reviewed and monitored.**
- **The CEO of the trust had an 'open door 'policy. The staff at the Kingfisher ward encouraged service users and their relatives to contact the CEO directly to express their views and suggestions about delivery and improvements of services in the ward.**

**Staff engagement**

- **The trust was taking the initiative to engage and integrate staff across the trust's three main locations by creating different opportunities. Information was sent to staff regularly by email and the trust's monthly newsletter'. Staff were encouraged to look at the staff intranet. Band 7 staff had regular meetings across all the three hospitals which gave them opportunities to share practices and learn.**
- **Staff's views and experience were captured in the work that was being undertaken by external consultancy in improving access and flow for the patients in the hospital. Staff told us that made them feel valued because their views were listened to by the trust's management.**
- **The trust had developed a celebration award for staff which required peer nomination. Staff we spoke with were complimentary about this process. Information about the award was published on the trust's website on the intranet and within newsletters. Another award scheme to recognise staff was known as DONA (Director of Nursing Awards). Staff were proud to tell us about nominations for these awards.**
- **The junior doctors told us they were able to raise concerns and the trust conducted junior doctor forums where they could express their views and share new ideas.**

**Innovation, improvement and sustainability**

- **The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service. We saw examples of innovation and good practice which are noted below.**
- **The trust had introduced dementia volunteers who were members of public who received dementia training form the trust. They visited the care of**

**elderly wards regularly and spent quality time with patients living with dementia by assisting them with various activities such as meal times, reading a newspaper or generally talking to them.**

- **The Kingfisher ward had an activity coordinator who planned and conducted different activities for patients after consulting them. A range of activities were covered, including arts and craft, music, dance, group lunches and movie time. We observed patients participating and enjoying these activities on the ward. For example; the activity coordinator had introduced a small 'gardening project' for the patients who enjoyed planting and gardening. Ward staff told us the relatives were also encouraged to join the patients for this activity.**
- **The service leads acknowledged that cost improvement was becoming more difficult. Service growth figures were high because of the increase in the number of patients, especially in unscheduled care. This had put a substantial financial challenge on the service. The service leaders were working collaboratively with financial partners and had identified a range of cost improvement plans (CIP). The medical services had plans to hold an event to focus on exploring key areas for CIP and process reviews. The service was working collaboratively with procurement, pharmacy, human resources and transformation team to maximise cross working. The service had considered different areas where cost improvements could me made such as patient transport, electricity, use of agency staff and use of consumables.**
- **The service leads considered 'safety and quality' as a priority in the CIPs and had an approach 'spend money to earn money'. For example, the medical staff told us that they got a say on preferred consumables rather than the cheapest consumables, and the service was working closely with procurement on standardising consumables to make sure that the quality standards were met. The medical leads were committed to improving services despite a challenging financial climate.**

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

## Information about the service

Andover War Memorial Hospital (AWMH) is part of Hampshire Hospitals NHS Foundation Trust. The hospital has a day care unit which provides elective day surgery for short procedures: (normally requiring up to one hour) that cover orthopaedic pre-assessment, minor surgical procedures, dermatology, and one-stop Flexible Sigmoidoscopy Service. Longer procedures: (requiring a morning or afternoon) covering orthopaedic (hand surgery), cataract and minor eye surgery, urology, dermatology, diagnostic Endoscopy.

This is a 10 bedded unit with two operating theatres for minor surgery. The unit is open from 8am to 6pm Monday to Friday.

We visited the operating theatres, recovery areas and the day care unit. We spoke with four patients, two relatives, and 10 staff which included doctors, nurses, healthcare assistants and a nurse manager.

We observed care and treatment and looked at eight care and associated records. We followed two patients to the operating theatres in order to gain a better overview of the patients' journey. These patients were undergoing elective surgery. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

Surgical services were rated good for safe and caring. They were rated as requires improvement for the effective, responsive and well-led services.

Incidents were reported on the trust electronic system and actions were taken at local level, although staff did not always share lessons learnt across the trust. The day care unit was clean and well maintained and infection control procedures were followed. Emergency equipment, such as a resuscitation trolley was available and checked regularly to ensure it was fit for purpose.

The service used the Five Steps to Safer Surgery checklist although this was not audited locally. Patients were risks assessed and monitored. However, an early warning score was not used as a formal process to monitor and escalate patients whose condition might deteriorate. Staffing levels were appropriate to the needs of patients.

Staff provided care to patients based on national guidance and evidence based practice. However, standards of care and patient outcomes were not being monitored through a clinical audit programme. Patient outcomes were measured for cataract surgery and the complication rate was low. Patient's pain was appropriately assessed and treated.

Staff had access to training to maintain their skill. However, their competencies were not regularly assessed and were not regularly reviewed. Staff worked

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in a multi-disciplinary way to provide care. GPs received discharge summaries in a timely way and there was a service level agreement for transfer of patients within the trust.

Patients received care and treatment from staff who were caring and compassionate. Staff across the day care unit treated patients with kindness and respect. Patients were involved in their care and treatment. Procedures had been fully explained and options discussed. Patients received emotional support and they felt prepared for their surgical procedures.

Patients for endoscopy were admitted at varying intervals during the day. However, patients undergoing orthopaedic and cataracts procedures did not have staggered admissions which is recommended to limit fasting and waiting times.

There was no evidence of service planning to meet local needs and the service was currently using less than 50% of its theatre capacity. Some referral to treatment times across were not being met in orthopaedic surgery and ophthalmology and patients were waiting over 18 weeks for surgery. Treatment times were being met in dermatology, gynaecology and urology. Patients' operations and procedures were being cancelled on the day of surgery because patient records were not available. This was not being monitored and improvements had not occurred. The service had one stop clinics and was developing a bowel diagnostic service.

Support for patients living with dementia or who had a learning disability was not consistently being accessed or used by staff. The day care unit did not provide separate or same sex facility as care was provided in an open unit which may compromise patients' privacy and dignity.

The day care unit service at Andover hospital did not have a specific strategy for development. . Staff were engaged, and felt connected to the trust, via the chief executive visits to the hospital. However, they were less engaged with the trust and their own surgical division. They did not, for example, participate in governance meetings or aware of governance matters which may affect the service.

Governance processes were at divisional level and were underdeveloped in the unit. There was limited evidence of local audit or monitoring of the service quality and risks.

Staff were positive about the local leadership of the service and felt supported by their immediate managers and worked well together. Patient feedback, via the Friends and Family test was used to improve the service.

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## Are surgery services safe?

Good

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

We rated safe as 'Good'.

Incidents were reported on the trust electronic system; actions were taken at local level. However, staff were not aware if these had been discussed at trust level and any wider lessons learnt.

The day care unit was clean and well maintained. Infection control procedures were followed by staff and hand hygiene gel points were available at the entrance to the unit for patients and visitors to use.

Medicines were stored securely in the day care unit; however in theatre the drug fridge was unlocked. Emergency equipment, such as a resuscitation trolley was available and checked regularly to ensure it was fit for purpose.

The service used the Five Steps to Safer Surgery checklist although this was not audited locally. Patients were risks assessed and monitored. However, an early warning score was not used as a formal process to monitor and escalate patients whose condition might deteriorate.

Patients told us they felt safe and did not have any concerns about current or previous care they had received at the hospital. Staff had an understanding of safeguarding processes and procedures. They were aware of the procedure for managing major incidents, and fire safety incidents. Staffing levels were appropriate to the needs of patients.

### Incidents

- The surgical services for the trust, of which the day care unit at Andover is a part, reported 15 serious incidents through the National Reporting and Learning System for the period May 2014 to April 2015. Of these incidents, slips, trips or falls accounted for the highest number of incidents.
- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. Staff stated they were encouraged to report incidents.
- Staff in the unit told us they received feedback on the incidents they had reported at local level. Minutes of monthly ward meetings confirmed that the themes of incidents were fed back to staff. Senior staff told us they reported incidents; they did not receive feedback from the trust.
- Senior staff told us of an incident where the wrong patient was taken to theatre, this was discovered in time and the patient suffered no harm. The incident had been reported, although senior staff were unable to access the report to demonstrate this. Senior staff told us the incident had been discussed with staff locally. Following the incident staff were reminded to follow the five steps to safer surgery checklist as the patient's name band was not checked in that instance. Staff were not aware if this had been discussed at trust level and any wider lessons learnt.
- Senior staff told us they did not take part in mortality and morbidity meetings and did not receive feedback from these meetings.
- The Duty of Candour legislation 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.
- Staff did not have an understanding of the Duty of Candour and their responsibilities in applying this in practice. Staff told us they had not received training about this.
- The trust had developed a policy which was signed off by the chief executive in May 2015. The policy talked about the trust statutory requirements and the "Being Open process." Senior staff we spoke with were not aware of this policy.

### Safety thermometer

- The trust collected safety thermometer data in relation to care provided to patients. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, venous thromboembolism (VTE),

catheter-related urinary tract infections and falls. Safety thermometer information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- The national harm free care data from NHS England (1 April 2014 and 31 March 2015) showed the trust performed well and had achieved 93% harm free care against the trust target of 95%.
- A trust audit relating to the use of preventative measures for the prevention of venous thromboembolism (VTE) was completed. The audit looked at 100 post-operative general surgical and orthopaedic patients. The sample consisted of elective and emergency patients and audit was combined with Royal Hampshire County Hospital. There were five cases of VTE between March and June 2015 at the trust which was below the expected number of four a month. The trust was achieving between 93% of patients who had their VTE risk assessments completed on admission against a monthly target of over 95%.

**Cleanliness, infection control and hygiene**

- The day care unit was spacious, airy and visibly clean. Daily cleaning logs showed cleaning was completed by staff on a regular basis.
- The anaesthetic rooms and theatres were visibly clean and access was restricted in line with infection control guidelines to prevent the spread of infection.
- Hand sanitizing gels were prominently located and at the entrance of the unit and in the day care area, as well as hand wash basins.
- Patients commented that the day unit was "very nice and clean". Two patients were aware of the local procedure for use of hand gel which was available at the entrance of the unit.
- We observed medical and nursing staff followed infection control practices by washing their hands between patients and they adhered to bare below elbow policy. Personal protective equipment (PPE) to prevent the spread of control of infection, such as gloves, aprons and scrubs, were available and used by staff as per trust policy.
- Hand hygiene audit was completed and this showed 100% compliance with procedures for infection control.
- Some patients admitted for elective surgery were screened for methicillin resistant staphylococcus aureus (MRSA) when they attended the pre-assessment clinics. However, senior nurse confirmed not all patients were screened for MRSA prior to surgery in line with the trust policy.
- The 'safe working staff' bundle and 'cleaning and decontamination' care bundle were in use. The day care unit had achieved 100% compliance following their audits in April 2015.
- There was no reported incidents of clostridium difficile (C.diff) and methicillin-resistant staphylococcus aureus (MRSA) in the day care unit.

**Environment and equipment**

- The day care unit had two theatres and one of these was exclusively used for endoscopy. The unit had eight day surgery trolleys and two ophthalmic trolleys.
- Staff followed the trust's procedure for the checking of emergency equipment to ensure this was fit for purpose. A random check of equipment showed regular checks were carried out and the dates of next service were recorded.
- The resuscitation trolley was checked daily and records were maintained. Appropriate resuscitation equipment was available in the theatre areas.
- The unit did not have facilities to sterilise equipment. Dirty equipment was sent to one of the acute hospitals on a daily basis and staff confirmed equipment was returned and available to them when needed.
- The day care unit had 10 trolley facilities; these trolleys were narrow and not suitable for bariatric patients. Staff were not aware of any other arrangements which could be accessed to meet the needs of these patients.
- Two new trolleys for eye surgery had been funded by the League of Friends to ensure suitable equipment was available. These were not for bariatric patients.
- Following a recent joint advisory group (JAG) accreditation, the service had put in place portable oxygen cylinders on patients' trolleys in line with JAG recommendations for endoscopy patients.

**Medicines**

- The day care unit had a small quantity of medicines which were held on site. All medicines were stored securely.
- Patients were prescribed medicines as required post-surgery and these were sourced from an external pharmacy. There was no facility on-site to provide take home medicines for day surgery patients.

- The day care unit had a number of medicines which were kept in the drug fridge and this was secure. The temperature of medication fridges were monitored, however the minimum and maximum temperature were not recorded. This meant staff did not know when the fridge temperature was either above or below the normal range. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines administered to patients.

**Records**

- A standardised protocol was used for pre-operative assessments. Pre- operative assessments were completed by staff for some patients. Information was sent to other patients when bookings were made and an assessment was completed on admission.
- There was a combination of electronic and paper records used. We reviewed medical and nursing notes, the records contained clear documentation of patients' medical history and any allergies were recorded. For diabetic patients the records included their recent blood sugar level. All patients' records were stored securely in the reception area and on the day care unit.
- Senior staff were not aware if audit of the Five steps to safer surgery was undertaken at Andover. Trust wide data showed audit carried out from January to March 2015 showed the trust used the checklist for 99% of patients in elective theatres.

**Safeguarding**

- Staff on the day care unit were aware of what constituted abuse and the actions they would take and how to report issues to protect the safety of patients in vulnerable situations.
- Staff would report to the senior sister and were confident to report higher up if they felt action had not been taken or needed to be taken promptly.
- Staff were aware of the trust whistle-blowing policy and we were told they could find information on the trust's website.
- There were safeguarding policies and guidelines for the protection of vulnerable adults and children. Safeguarding adults and children training was part of the trust's statutory and mandatory training programme.
- Seventy two percent of staff, within the surgical division, at this hospital, had completed safeguarding adults and children training (April 2014 to March 2015), compared with the trust target of 80%.

**Mandatory training**

- The trust had an induction programme for all newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules. Staff told us they also undertook some on line training as part of their induction.
- At Andover, 12 staff had completed the advanced life support (ALS) and they were tested and certificated regularly to ensure staff maintained their skills.
- Data provided by the trust indicated that in the last 12 months 80% of required staff had undertaken the local induction. Overall, 81% of staff in the surgical division, at this hospital, had completed their statutory and mandatory training (April 2014 to March 2015). Staff we spoke with reported they had sufficient time to complete this training.

**Assessing and responding to patient risk**

- Risk assessments were undertaken as part of pre-operative assessment and covered health measures, for example, blood pressure and BMI, and also included malnutrition status, venous thromboembolism, and pressure ulcer risks.
- The Five steps to safer surgery checklists (based on the WHO Surgical Safety Checklist) should be used at each stage of the surgical pathway to prevent errors. This was used for surgery and had also been adapted for patients undergoing endoscopy. We observed the checklist had been completed in the records seen. There had not been a recent audit of the checklist in the service.
- Patients who had received sedation as part of their procedure were monitored. Staff said they undertook two sets of observations post procedure and we saw this was followed. They did not use any tool such as the national early warning score (NEWS) to identify deteriorating patients. This meant staff did not have consistent escalation process they followed to ensure prompt access to medical support. However, staff said they would call emergency services for help and support, clinical staff were also ALS trained.

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### Nursing staffing

- There are nationally defined minimum safe staffing levels for day care wards. These include Safe Staffing: A Guide to Care Contact Time (NHS England, November 2014) and Direct Care Measurements (NHS England, January 2015).
- The day care unit had core staff who had worked there for a number of years. They had a mixture of full and part time staff which included an operating department practitioner and bank staff.
- The unit was staffed with a multi-flexible team of registered nurses, theatre practitioners and healthcare support workers, who are able to work in all areas of the department
- Senior staff confirmed they did not use the safer staffing tool to assess their staffing levels. Staffing level was calculated according to the list and they used bank staff if extra support was needed. There were adequate staff with the right skills to provide care to patients. During our inspection the staffing ratio of registered nurse to patient was above the expected level of 1:6. There was a registered nurse providing escort of patients who had received sedation post- surgery. Information from lists, rotas and the staff confirmed the staffing ratio was usually 1:3 patients. Patients told us they did not have to wait long and staff were available and kept them informed regarding the order of the theatre list.
- There was not a nurse endoscopist at Andover.

### Surgical staffing

- Consultants and registrars from the RHCH, Winchester trust carried out minor surgery and other investigatory procedures and endoscopy at Andover.
- Surgical consultants told us they were staffed appropriately with the right skill mix for the unit.
- Senior staff told us there was only one list per month where patients received general anaesthetic. The anaesthetist remained on site for this list until the patients were fully recovered.

### Major incident awareness and training

- Staff followed the trust major incident contingency and local safety plan for fire safety and evacuation.

## Are surgery services effective?

Requires improvement

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

We rated effective as ''requires improvement.''

Staff provided care to patients based on national guidance and evidence based practice. However, standards of care and patient outcomes were not consistently being monitored through a clinical audit programme.

Patients for endoscopy were admitted at varying intervals during the day. However, patients undergoing orthopaedic and cataracts procedures did not have staggered admissions which is recommended to limit fasting.

Staff had access to trust policies on the intranet. However, many staff did not know how to find these and some policies reviewed were not up to date.

Staff completed an induction when they joined the service and could access training to maintain their skills. However, their competencies were not regularly assessed and were not regularly updated.

Patient outcomes were measured for cataract surgery and the complication rate was low.

Patient's pain was appropriately assessed and treated. Patients were confident that pain control would be prescribed if needed. Diet and fluids were available post-surgery or procedures, and menu choices were available. Patients with diabetes were appropriately monitored.

Staff worked in a multi-disciplinary way to provide care. GPs received discharge summaries in a timely way and staff followed their discharge criteria. The day care unit did not provide a seven-day service. There was a service level agreement for transfer of patients within the trust.

Staff were aware of procedures to follow if a patient lacked capacity to ensure decisions were made in the patient's best interests and consent to care was sought and recorded.

# Surgery

### Evidence-based care and treatment

- Staff provided care and treatment to patients based on national guidance such as the National Institute for Health and Care Excellence (NICE). These included pre-assessments prior to day surgery using a standardised tool. Tests were carried out according to patients' underlying conditions and advice given such as fasting if required. Diabetic patients had their blood sugar monitored and were also prioritised on the theatre lists. The sedation protocol was followed.
- The Joint Advisory Group on Gastrointestinal Endoscopy 2014 had found the day care unit met the accreditation standards framework.
- In line with guidance from NHS England, patients over 55 years of age were offered flexible sigmoidoscopy as part of the bowel cancer initiative.
- Cataract surgery had been audited in 2014. However, there was no evidence of a regular ongoing audit programme in the day care unit.

### Pain relief

- Patients' pain was assessed and pain control was prescribed as required and formed part of the pre assessment. However, staff said there was no pain link nurse or input from pain team available at the day care unit. Patients would be referred to the main trust sites if needed.
- Patients told us they had not required pain control on previous visits. Staff had advised them to take pain control on discharge as required.

### Nutrition and hydration

- Patients admitted for day surgery were provided with snacks and light meals following their operation. Staff ensured they had received food and fluids prior to discharge. Advice on fasting if necessary was provided as the time bookings were made.
- Most patients had either throat spray or light sedation and were able to take a light diet prior to discharge.
- Patients who were diabetic had their blood sugar monitored.
- Patients for endoscopy were admitted at varying intervals during the day. However, patients undergoing orthopaedic and cataracts procedures were all admitted at the same time and consented by the consultants before they started their list. This was not in line with good practice guidance (British Association of Day Surgery, 2012) which recommends that there should be staggered admissions to limit fasting and waiting times.

### Patient outcomes

- Andover hospital did not participate in national audits. There were no audits this service should be participating in as they were undertaking minor surgery. At the time of the inspection staff said they were undertaking an endoscopy audit.
- Between September 2013 -2014, the trust audited 1245 cataract operations treated at the Royal Hampshire County Hospital and Andover War Memorial. 97% of patients were recorded as having no operative complications. No post-operative complications occurred in 88% of patients. The most common complications were swelling and inflammation. A complication called cystoid macular oedema, which can lead to reduced visual acuity and the need for prolonged courses of treatment, were reported in 21 cases (1.7%). This was comparable to data from the UK National Cataract Data Set (1.6%).
- There was no local data on patient outcomes, for example, patient reported outcomes measures.

### Competent staff

- The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules.
- Staff undertook role specific training to maintain and develop their skills such as use of certain equipment in theatre at this hospital. Staff records contained competency assessment; however these were not updated and senior staff did not know about the frequency that assessments should be completed. They were not able to find this information on their website at the time of the inspection.
- The General Medical Council (GMC) National Training Scheme Survey 2014 reported the trainee doctors within surgical specialities rated their overall satisfaction with training as similar to other trusts. Junior doctors at the other hospitals told us that training was good and they had planned weekly training sessions.

# Surgery

- Appraisal rates for the surgery division, for the period April 2014 to March 2015, varied by staff group and the team worked in. The average completion rate for appraisals was 73% against a trust target of 80%.
- The service had team meetings, there was no formal arrangements for staff's supervision in order to identify staff's development and training needs.

**Multidisciplinary working**

- Staff told us that multidisciplinary team (MDT) working across the hospital was good and they were able to access advice from Winchester as required. Patients were referred back to their GPs.
- There was a service level agreement for day care patients requiring admission, to be transferred to RHCH, Winchester which is part of the same trust.
- Staff said they had good relationships with the doctors, and patients had access to specialist advisors such as diabetic nurses. Access to therapist input was via RHCH, Winchester or the community team.

**Seven-day services**

- The day care unit was operational from 8am to 6pm, Monday to Friday only.
- There was no anaesthetic cover overnight. Patients needing to stay overnight were transferred to RHCH, in Winchester.
- There is no pharmacy department at Andover War Memorial Hospital. They do have a clinical pharmacy service and a pharmacy technician visits three times a week and a pharmacist one day a week.

**Access to information**

- Staff had access to relevant information in order to deliver effective care and treatment in the patients' best interest. Staff said they would access these from the trust's internet. However staff could not find the policies when we asked to see them. Some policies were out of date. For example, the policy on file for resuscitation had expired in 2013 and had not been reviewed to ensure it reflected current practice: senior staff had difficulty finding these on line.
- Discharge summaries for GPs were seen and these were completed at the end of the surgical list. A copy was also given to patients on discharge and staff confirmed these were sent to patients' GPs within 48 hours. These informed GPs of the patient's medical condition and the treatment they had received.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Patients were asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were followed to ensure decisions were made in the best interests of patients. The trust had introduced some new patient documentation and MCA assessments although these were not in use at Andover.
- Patients were given clear explanations about the surgery and procedures and staff had checked that they understood what they were consenting to.
- For patients undergoing certain procedures the nurses completed the patients' consent to these procedures, with the procedures being performed by a doctor. We could not find any evidence of additional training undertaken by the nurses for taking patients consents when the procedure was undertaken by others.

## Are surgery services caring?

Good

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

We rated caring as 'good.''

Patients received care and treatment from staff who were caring and compassionate. Staff across the day care unit treated patients with kindness and respect. Patients and relatives told us they received good service which was centred around their needs. The NHS Friends and Family result showed high satisfaction with the service and the majority of patients would recommend the service.

Patients were involved in their care and treatment. Procedures had been fully explained and options discussed. Patients emotional needs were supported and they felt prepared for their surgical procedures.

**Compassionate care**

- Patients were complimentary about their care and told us they much preferred attending the day care unit as it had a comfortable and relaxed atmosphere and they had received, for example, a "very good" and "superb service" and care on previous visits.

# Surgery

- Staff were passionate and committed about the care and treatment they provided, and we observed positive interactions with patients in all the hospitals we visited
- The NHS Friends and Family test results for the trust (August 2014 to March 2015) showed that 95-99% of patients would recommend the trust as a place to receive care and treatment which was similar to the national average.

**Understanding and involvement of patients and those close to them**

- Patients were involved in the care and provided with information which they said was comprehensive and family were involved as appropriate.
- Procedures were fully explained and this included after care. Where options had been available these had been discussed. Patients had been able to question decisions and influence their care such as whether to opt for sedation or alternative treatment.

**Emotional support**

- Patients and relatives told us they received the support they needed to manage their treatment and hospital stay. For example, a relative said the staff had been "supportive and very helpful".
- Patients told us they had been reassured by staff and they felt prepared for their procedure and minor surgery.

## Are surgery services responsive?

Requires improvement

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

We rated responsive as 'requires improvement'

There was no evidence of service planning to meet local needs and the service was currently using less than 50% of its theatre capacity. The trust did not have data specific to Andover. However, trust referral to treatment times were not being met in orthopaedic surgery and ophthalmology and patients were waiting over 18 weeks for surgery. Treatment times were being met in dermatology, gynaecology and urology.

Patient operations and procedures were being cancelled on the day of surgery because patient records were not available. This was not being monitored and improvements had not occurred.

Patients for endoscopy were admitted at varying intervals during the day. However, patients undergoing orthopaedic and cataracts procedures did not have staggered admissions which is recommended to limit waiting times during the day.

Support for patients living with dementia or who had a learning disability was not consistently being accessed or used by staff. The day care unit did not provide separate or same sex facility as care was provided in an open unit which may compromise patients' privacy and dignity.

Patients requiring overnight stay were appropriately transferred to Winchester A&E until a bed could be found. The service had one stop clinics and was developing a bowel diagnostic service. Patients felt the staff were responsive and provided them with clear information about their surgery. There was a variety of leaflets explaining the procedures which patients said were useful although all were only available in English.

Staff followed the trust's procedure for dealing with complaints and patients were overall satisfied with the service they received.

**Service planning and delivery to meet the needs of local people**

- Andover hospital provides day care minor surgery to patients living in Andover and the surrounding areas. Patients are referred by their GPs to the specialist consultant at Winchester hospital.
- The day care unit ran one stop clinics for colorectal and gynaecology procedures and the treatment of cataracts.
- There were plans to expand the service with the development of bowel scope due to commence in November 2015. This would include 11 lists per week which would be shared across the three sites.
- There was no data in relation to service planning to meet local needs. A member of staff commented that they did theatre lists at RHCH, Winchester on Saturdays and but was not aware of any plans to expand the service similarly at Andover.

# Surgery

### Access and flow

- There was no local data for Andover Hospital. However, trust data showed that referral to treatment time within 18 weeks for Ophthalmology (87.5%) and Orthopaedics (84.1%) was below the national standard of 92%. The trust was meeting the standard for dermatology and urology.
- The day care unit was under-used. Data from the trust showed less than 50% of the available capacity was being used. From February and April 2015 Theatre 1 usage varied between 40-48%. During the same period in Theatre 2 usage was between 27 and 36%.
- Of the 20 theatre sessions available per week, an average of nine were being used. Less than 50% of the available capacity was being used. This included two to four sessions of non-endoscopy cases and five to seven sessions for endoscopy cases. These included upper and lower gastroenterology investigations, urology and gynaecology.
- Staff said there were a number of cancellations on the day of surgery due to patients' records not being available. Senior staff told us they were not aware of any audit on missing records, nor the number of operations which had been cancelled due to records not being available.
- Patients for endoscopy were admitted at varying intervals during the day. However, patients undergoing orthopaedic and cataracts procedures were all admitted at the same time and consented by the consultants before they started their list. This was not in line with good practice guidance (British Association of Day Surgery, 2012) which recommends that there should be staggered admissions to limit fasting and waiting times.
- The service did not have a set procedure for managing day case lists known as "smart lists". That is for patients that might need longer to recover to be seen first. However, we were told patient with diabetes and patients needing transport were seen first.
- The service had appropriate discharge criteria. There was no facility for day care patients to be accommodated at Andover if they needed to stay overnight. They were transferred to A&E at RHCH, Winchester until a bed could be found. Data received from the trust showed between March – June 2015, eight day patients became inpatients.

### Meeting people's individual needs

- Patients had access to written information regarding the type of operations or treatment they had planned for them. Information was sent to patients with booking information and some information was available at the pre-assessment clinics. However, all information was only available in English and one staff member said they could have some in large prints if requested from the trust.
- Staff had received training in dementia care. Across the trust, staff had adopted symbols for patients who were living with dementia. However, staff were not using this at Andover War Memorial Hospital. One staff member told us they would access support for patients with a learning difficulty from Winchester hospital; however two other staff were not aware of this.
- Patients were complimentary about the care and treatment and the facility at this service. Some patients had come from Winchester and did not regard this as a problem, as the service met their needs, parking and access was good.
- The day care unit was open plan and did not have separate areas to care for male and female patients. Staff told us this was "a challenge" and they tried to segregate patients at each end of the units.
- Separate toilet facilities were available for patients. However, these were accessed through the main ward area and may compromise patients' dignity.
- There was level access to the day care unit, which was accessible for patients with limited mobility or wheelchair bound. Patients were complimentary about the parking facilities and said they did not mind travelling from Winchester.
- Patients were provided with a suitable day lounge which was bright and airy and had a "homely" feel which the patients appreciated.

### Learning from complaints and concerns

- There was a process that the staff followed in dealing with any concerns or complaints.
- The service received a high level of compliments and few concerns.

# Surgery

- There was no information available on display about raising concerns or complaints. Patients and their relatives said they would speak to the nurses; although they wanted to stress they were "very happy" with the care.
- All patients who raised a complaint received a written apology from the chief executive officer (CEO). Contact information for the CEO was available on the trust's website to enable patients to raise their concerns.

## Are surgery services well-led?

Requires improvement

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

We rated well-led as ''requires improvement.''

The day care unit service at Andover hospital did not have a specific strategy for development. and they were less engaged with the trust and their own surgical division. They did not, for example, participate in governance meetings and some were unaware of governance matters which may affect the service.

Governance processes were at divisional level, and were underdeveloped in the unit. There was monitoring of performance and quality at division's level and trust wide dashboard but limited evidence of local audit or monitoring of the service quality and risks.

There was a strong emphasis on consultant led service. However, there were not a plan to address some of the service issues, for example, the under use of theatres.

Staff were positive about the local leadership of the service and felt supported by their immediate managers and worked well together. Patient feedback, via the Friends and Family test was used to improve the service. Staff did not identify any innovations or improvements developed in the day care unit.

### Vision and strategy for this service

- The vision for the surgical division was primarily focused around the trust's vision for a planned critical treatment hospital (CTH). All emergency surgery would take place at the new hospital. The director of surgical services had a clear vision around how the surgical services would be distributed and effectively run between the new hospital.
- The divisional leads had oversight and strategy plans in place to improve services for patients currently, by addressing workforce challenges, efficiency issues and to improve and develop cross-site working across the current trust hospital locations. However there was not a strategy for Andover, for example, to address the under use of theatre capacity at the hospital.
- There was a strong emphasis on a consultant led-service, to achieve the best possible outcome for patients.
- Staff at Andover were not aware of any the trust's strategy and whether this included changes to their own service.

### Governance, risk management and quality measurement

- There was a clear governance structure and process within the surgery division. Governance meetings took place on a monthly basis, which included monthly morbidity and mortality meetings (MM). The clinical governance report also reported on finance and performance and quality issues within the division. It looked, for example, at serious incidents, cases of hospitals acquired infection, compliance with hand hygiene audits, performance against referral to treatment time targets (RTT).
- The trust undertook a number of audits in order to improve the outcome for the patients. There was a divisional risk register which clearly identified the risks within the department, such as patient flow and the implication on quality and finance. This did not include Andover hospital.
- The service had regular team meetings where concerns and complaints were discussed. There were no discussions about key performance indicators and governance parameters. Senior staff in the day care unit did not have information on returns to theatre, unexpected transfers to the main hospitals. They did report incidents; however there were no records available and senior staff were not aware of outcomes of incidents reported. There was a disconnect between day care unit and the wider trust.

- The unit manager did not attend trust's governance meetings and no reports from governance meetings were available.

**Leadership of service**

- The service has a manager who provided clinical support ,and staff told us they worked well as a team and they were focussed on best outcomes for patients.
- The leadership in surgery did not demonstrate that there was a focus on the services at this hospital.

**Culture within the service**

- Staff spoke positively and were passionate about the service meeting the needs of local patients and the surrounding areas**.**
- There was an open culture and staff were confident in reporting any issues**.**
- Staff said they felt management listened to their views through initiatives such as the staff surveys. Staff valued the introduction of the WOW awards and DONA awards, where teams and individuals were acknowledged for the care, commitment and compassion they had shown. The service displayed certificates for any nominations and awards they had won which could be seen by patients.

**Public engagement**

- Patients and their relatives were encouraged to provide feedback through the N HS Friends and Family test. The trust reported on the response rate as part the monthly scorecard. The latest FFT showed patients were 94% were positive about their care and treatment. Participation level was low at 30%.
- Staff encouraged patients to complete the surveys which were given at the end of the day. Patients were encouraged to provide feedback and this was analysed to improve the care provided.

**Staff engagement**

- The chief executive was visible and staff spoke highly of their approach and management style. Staff had regular in touch meetings with the chief executive and they said it helped to link them with the wider trust. However, staff did not feel connected to the wider trust. They did not know of development plans for the service. The vision and strategy were at division level and staff were not engaged with this at a local level.

**Innovation, improvement and sustainability**

- There was a cost improvement programme (CIP) in place within the division. Sixteen areas had been identified for savings to be made, including patient transport, procurement costs and course fees. A new transport policy had been introduced in response to the CIP. There were more stringent guidelines for patients who could access patient transport services paid for by the trust. There were no specific CIP's in place for the Andover surgery service.

# Maternity and gynaecology

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Hampshire Hospitals Maternity Centre is based at Andover War Memorial Hospital and is part of the Hampshire Hospitals NHS Foundation Trust. The maternity centre provides midwife led maternity care to the community of Hampshire. Between March 2014 and March 2015 there were 118 births at the Maternity Centre.

There are two birthing rooms, one of which contains a birthing pool. Ante natal and post-natal care is also delivered at the site. Women have access to a separate room where they could stay after they had delivered their babies until they were ready to go home. The service was not routinely staffed overnight. Midwives were contacted via labour line if a woman thought they were in labour and had chosen to deliver their baby at the maternity centre. Women were told to attend the centre where the on call midwife would meet them.

A small amount of gynaecology out patients clinics are conducted at Andover War Memorial Hospital such as the one-stop menstrual disorders clinic. There was also a weekly day surgery hysteroscopy service.

During our inspection we spoke with four women at the centre. None of the women had delivered their babies at the maternity centre but were attending for routine ante natal and post-natal care. We also spoke with three partners and nine members of staff; these included managers, midwives and maternity support workers. We held a focus group attended by a further four midwives. Before and during our inspection we reviewed the trusts performance information.

Services on all hospital sites are run by one management team (the family and clinical support services division) and as such, are largely regarded within the trust as one service, with some staff rotating between the sites. For this reason some duplication of service evidence will be seen across the service reports on three locations.

# Maternity and gynaecology

## Summary of findings

We found maternity services were good for providing safe, effective, caring, responsive and well led services.

Midwifery staff were encouraged to report incidents and robust systems were in place to ensure lessons information and learning was disseminated trust wide.Procedures to protect people from abuse and avoidable harm were being followed. Midwife staffing levels were appropriate to provide one to one care.

Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance. Policies and guidelines were developed in line with the Royal College Of Gynaecologists (RCOG), Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust for the maternity service to ensure all services worked to the same guidelines.

Although patient outcomes were recorded on the trust wide maternity dashboard, outcomes appropriate for a midwifery led centre were not being measured and recorded. This needed further development.

Women throughout the service consistently gave us positive feedback about the care and treatment they had received. We observed women were treated with dignity and respect and were included in decision making about their care. Women were able to make choices about where they would like to deliver their babies. Women and families had access to sufficient emotional support if required.

There was a strategy and vision for the service which was focused towards the development of a new hospital. However, there was not a specific strategy or plans for the maternity centre in the short and medium term. The overall plan was for the service to remain open to increase choice for women but the plans to increase birth rates or expand and develop the service were not developed.

There were comprehensive risk, quality and governance structures and systems were in place to share information and learning. Staff across the service described an open culture and felt well supported by their managers. Staff continually told us they felt “proud” to work for the trust.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good

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

We rated safe as 'good'.

Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses. Incidents were thoroughly investigated and lessons were learnt and communicated widely to support improvement in other areas as well as services that are directly affected.

All patient areas were visibly clean and the cleanliness of the environment was monitored

in line with trust policy.Staff followed infection prevention and control practices.

Appropriate equipment was available and was well maintained. However, the centre did not have its own defibrillator and this was shared with the day surgery unit. There was a potential risk that out of hours, timely access to the defibrillator may be compromised if the midwife was working on their own.

Medicines were appropriately stored although some medicines were being stored temporarily in a fridge that could not be locked.Action was being taken to reduce the risk of unauthorised access.

Staff were clear about their roles and responsibilities, and processes to follow to

safeguard women and babies from abuse.Staff recognized and responded appropriately to changes in clinical risks for women who used the Maternity Centre. Midwife staffing levels were appropriate to provide one to one care.

### Incidents

- All grades of staff we spoke with were aware of the incident reporting system and understood their responsibilities to report incidents, accidents and near misses. They all told us senior staff and managers encouraged them to report "anything they were concerned about". Most staff we spoke with told us they had feedback via email to inform them of the outcomes of investigations conducted as a result of their incident report.
- Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed. For example in response to an increase in incident reporting with regards to Obstetric Anal Sphincter injuries (OASI) the trust had implemented further training and guidance which ensured all midwives followed consistent procedures for the prevention of OASI.
- As a result of incident reporting in another maternity unit within the trust, cardiotocography (CTG) monitoring was not performed at the maternity centre. Four midwives told us this was because they did not have up to date equipment to enable them to conduct the monitoring safely.
- Daily trust wide conference calls were held to discuss trust wide concerns. Incident reports for the previous 24 hours were discussed and actions planned for further investigation.
- Hospital trusts have a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm, this is known as Duty of Candour. All grades of staff we spoke with were aware of the principles of Duty of Candour. Staff explained how women were informed about investigations into any incidents which related to the care they had received. We were told by senior nurses that there had been no trust wide training, however the electronic incident reporting system contained a section on openness to remind staff of their responsibilities

### Safety thermometer

The maternity service did not participate in the Safety Thermometer audit. This was because women did not stay overnight in the service. They assessed and monitored safety information which was considered to be more appropriate to the service. For example incidents and formal complaints. Results were displayed on the walls of the centre.

### Cleanliness, infection control and hygiene

- All clinical areas were visibly clean and staff were seen cleaning equipment after use.

- We saw staff adhered to the trust's infection control policy. For example, we observed staff were bare below the elbows and were seen washing their hands and using hand gel appropriately Information was clearly displayed above sinks in all areas to remind staff about correct hand washing procedures.
- Personal protective equipment was available and staff were seen changing gloves in between patients to prevent the risk of cross infection.
- We saw copies of the hand hygiene audits and saw staff in the centre had regularly attained 100% and adhered to the trust infection control policy.
- Cleaning checklists were displayed outside clinical rooms**.** The check lists gave information about when the room had last been cleaned and when another clean was due.
- Housekeeping and domestic staff cleaned the centre daily and this was monitored by the maternity support workers (MSW). The MSWs told us the cleaning of clinical equipment was a team effort, however they were responsible for the maintenance of cleanliness if the midwives were busy. They told us all equipment was cleaned in the morning and after each use. Equipment appeared visibly clean; however there was no indication that cleaning of clinical equipment and other equipment such as beds, cot or birthing pool had occurred or had been monitored.

**Environment and equipment**

- Emergency adult resuscitation equipment in the form of a defibrillator was not available in the centre. The nearest defibrillator was stored in the day surgery unit. There was a potential risk that out of hours, timely access to the defibrillator may be compromised if the midwife was working on their own.
- There was one emergency baby resuscitaire. Daily safety checks of this equipment were documented.
- A range of equipment to aid labour was available. This included one birthing pool, bean bags, and birthing balls.
- Equipment, such as a portable sling, was available to evacuate a woman from the birthing pool in the event of a collapse.
- Entry to the unit was via buzzer system. Women and their partners had to press the buzzer to gain access, however they could exit the unit freely by pressing a button on the wall. Midwives did not feel there was a security risk; because the centre was small they were aware of who was in the building at all times.
- All clinical equipment displayed a sticker which gave information which detailed when it had been serviced and tested. We noted that all equipment had been checked within the last 12 months.
- Some midwives were concerned about accessing the building on their own out of hours. They told us they met the woman and partner at the maternity centre and stayed with them on their own until the woman was nearing the delivery stage. At that stage the midwife contacted a community midwife to assist with the delivery. When the midwives left the building they contacted labour line to inform them, and contacted them again when they got home. This was to ensure labour line were aware that staff had got home safely. The Trust stated, that two midwives were now allocated immediately and if one came in later that was by "local arrangement" by their other partner midwife.

**Medicines**

- Medication that required storage at low temperatures was kept in a fridge. The medication fridge had broken, and a replacement fridge had been ordered. Medication was stored in a temporary fridge which was not lockable. The fridge was stored in a small room that also contained emergency medication in the event of post-partum haemorrhage, anaphylaxis and adult resuscitation. The medication was not stored in tamper evident boxes. The room was situated between the two delivery rooms and access could be gained through the delivery rooms or via the main corridor in the centre. None of the doors in to the storage room were able to be locked to prevent access by unauthorised personnel.

**Records**

- Pregnant women carried their own records. These were completed on their initial ante-natal booking and were maintained throughout their pregnancy through to the completion of their care by maternity midwives.
- Each baby was issued with the child health 'red book'. One woman told us the midwife had completed the information about their baby in the red book.
- When a pregnant woman contacted labour line, documentation was completed with regards to the woman's history and current concerns. This information

was sent via secure email to the maternity centre if a decision had been made for the woman to attend for further advice. Midwives told us this gave them in-depth information prior to the woman's arrival at the unit and reduced the need for repetitive questions

**Safeguarding**

- All of the staff we spoke with were clear about their roles and responsibilities and the processes and practices that were in place to keep women safe and safeguarded from abuse.
- A safeguarding midwife was based at the maternity centre. Their role was to assess women who had been identified as requiring additional support. They monitored the women monthly to ensure they had attended regular meetings and support sessions. The safeguarding midwife worked collaboratively with the lead safeguarding midwife for the trust.
- We spoke with the senior midwife who had the lead role for safeguarding across the Trust. They described how they worked closely with the lead midwives for substance misuse and mental health to ensure robust protocols were followed if concerns had been raised. Women and babies who were considered at risk were flagged on the computer system and pathways were in place to enable all midwives to care for them appropriately. Joint working had been established with external agencies and monthly meetings were held to discuss any areas of concern. Information was disseminated to community midwives and health visitors to enable them to support women and babies in the community.
- All of the midwives we spoke with described the safeguarding lead as approachable and felt they could contact them at any time for help and advice if required.
- An audit had been conducted trust wide in November 2014 to assess compliance in the completion of the management plan used for safeguarding children and maternity cases. The audit was conducted to assess if compliance met with the guidance produced by the trust (maternity safeguarding children guidelines 2014) and the local safeguarding children board (4LSCB Maternity and Children's Services Department unborn babies protocol 2011 (revised 2013)). The audit found areas of good practice and areas for further improvement. An action plan and further recommendations were developed with deadlines for completion.
- We were not sent specific training figures for midwives who worked at the maternity centre; however all of the midwives we spoke with told us they had attended safeguarding training.

**Mandatory training**

- Mandatory training sessions were held at the maternity centre to enable all staff to attend. Posters were displayed in staff areas detailing session times and content. All the staff and managers told us they were up to date with their mandatory training.
- Maternity staff also attended an additional day's mandatory skills and drills training. Part of this day included a skills session on evacuating a collapsed woman from the birthing pool.

**Assessing and responding to patient risk**

- Robust risk assessments (which included medical history) and booking criteria were in place to ensure women were safe to deliver their babies at the Maternity Centre. These were monitored and reassessed during women's ante natal care to ensure the women remained suitable to deliver their baby at the maternity centre.
- Midwives were familiar with guidelines for the emergency management for post-partum haemorrhage and actions to take to transfer a woman to a consultant led unit by ambulance.
- Midwifery staff completed the modified early obstetric warning score (MEOWS) to assess women's observations. The score recorded routine physiological observations such as blood pressure, temperature and heart rate. The scoring system gave protocols for staff to follow if the observations deviated from the woman's norm.

**Midwifery staffing**

- Midwives told us there were times when they felt they were very busy. 15 whole time equivalent (WTE) midwives were employed at the centre. There were also three maternity support workers and one ward clerk.
- Daily conference calls were held with the community teams trust wide, to assess the workload and address any shortfall in staffing due to sickness or where midwives had been required to work overnight. This facilitated the redeployment of midwifery staff across the trust to cover any areas that may require further support.

# Maternity and gynaecology

- Data showed midwives consistently provided one to one care for women in established labour. Midwives said this enabled constant monitoring and prompt reactions to minimise potential risks.
- Out of hours, midwives were contacted by Labour Line and informed a woman would be arriving at the maternity centre. Women were told to allow 30 minutes for the midwife to arrive. The midwife called for further help from the on call community midwives if the delivery of a baby was imminent.

**Medical staffing**

- Midwives described good working relationships with local GPs and community midwives who shared the care of pregnant women.
- Obstetricians were not employed to work at the maternity centre. However, there were two consultant led ante natal clinics each week. Midwives of all grades told us the consultants were supportive and they could contact them for further guidance if required.

**Major incident awareness and training**

- The trust had suitable major incident plans in place. A major incident policy was in place for all trust staff and outlined how Hampshire Hospitals NHS Foundation Trust would respond in the event of an emergency (major incident). Major Incident training was included on the trust corporate induction and in the local induction for all new staff.

## Are maternity and gynaecology services effective?

Good

**By effective, we mean that people's care, treatment and support achieves good outcomes,**

**promotes a good quality of life and is based on the best available evidence.**

We rated effective as 'good'.

Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance. Policies and guidelines were developed to reflect national

Guidance there was a local programme to monitor care standards. Patient outcomes were recorded on the trust wide maternity dashboard. However, the information was not relevant to a midwifery led centre. Many of the outcomes recorded were not appropriate to a midwifery led centre and the appropriate outcomes had not been recorded. For example the venous thromboembolism (VTE) assessment rate, initiation of breast feeding rate and third and fourth degree tears, were not recorded.

Women had a comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Pain relief was managed using equipment, such as a birthing pool and hypnotherapy-birthing techniques rather than drug therapy or gas and air therapy. The transfer rate of women for better pain relief was low.

Staff had access to training to develop and maintain their competencies. However, some noted that there were not supported opportunities for professional or career development. The supervisor to midwife ratio was in line with national guidance of 1:15 and all staff said they had received appraisals.

Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). Consent guidelines were followed appropriately.

**Evidence-based care and treatment**

- Care and treatment took account of current legislation and nationally recognised evidence based guidance. For example, women identified as having low risk pregnancies could choose to deliver their baby at the maternity centre. A midwifery led unit is regarded as the safest option for low risk pregnancies (Maternity Matters, 2007, DH, Birthplace; 2011, NICE clinical guidance 190)
- Policies and guidelines were developed in line with the Royal College of Obstetricians and Gynaecologists (RCOG), Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust for the maternity service to ensure all services worked to the same guidelines.
- There was an on-going audit programme to evaluate care and change practice if required. For example an audit had recently been conducted in response to the varying practice for stretch and sweep (A stretch and

sweep is one way of initiating labour and is considered a gentler, less invasive induction option. It is generally done when a mother is past her due date). Guidance had been subsequently developed, as a result of the audit to enable the delivery of standardised care.

**Pain relief**

- Various equipment was available to alleviate pain in labour such as a birthing pool and bean bags.
- Midwives told us on the whole they used hypnotherapy-birthing (self-hypnosis, relaxation and breathing techniques) to aid pain relief. Women were able to attend ante natal clinics where they learnt the necessary skills required for hypnotherapy-birthing.
- There had been two women who were transferred out of the unit for pain relief in a 12 month period. This was not significant, and the overall transfer rate was very low.

**Nutrition and hydration**

- Women had access to food from the restaurant based in the main part of Andover War Memorial Hospital during normal working hours. Drinks were available in the maternity unit and midwives were able to make small snacks for women and their partners if required.
- The trust had recently received accreditation with the UNICEF Baby Friendly initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed by UNICEF.

**Patient outcomes**

- Patient outcomes were recorded on the trust wide maternity dashboard. We reviewed the dashboard and saw that most of the recorded outcomes were not appropriate to a midwifery led centre, for example, outcomes on the venous thromboembolism (VTE) assessment rate, initiation of breast feeding rate and third and fourth degree tears was absent. We requested further information from the trust to enable us to assess how outcomes were measured at the centre. No further information was made available; consequently we were unable to evaluate how the trust measured the outcomes of care delivered at the maternity centre.
- The community operational manager told us that their transfer rate to hospital was 14%. This compared to a national average of 24% for units of the same type. Midwives discussed reasons for transfer and gave women choices in line with (NICE guidelines, CG190, 2014).
- 70% of women who delivered at the centre were multiparous (women who have borne more than one child) compared to 30% of women who had not delivered a child before. 92% of women had delivered their baby in the birthing pool.

**Competent staff**

- Midwives employed to work at the maternity centre had the necessary skills and experience to practice autonomously. Midwives told us only experienced band six midwives were able to work on their own out of hours on the unit. This was because there was no consultant input and consequently maternal, foetal and baby risk assessments had to be completed and reviewed, comprehensively and competently at all times.
- Three midwives had attended training and had the necessary skills to complete new born baby checks in line NHS New-born and Physical Examination Programme. These checks were completed to detect and promptly treat a number of congenital medical conditions.
- All midwives were assigned a supervisor of midwives. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM).The supervisor of midwives is someone who has been qualified for at least three years and has undergone further training to enable them to fulfil the role. (rule 8, Nursing and Midwifery Council (NMC) 2012) .The supervisor of midwives provides advice and support, audits midwives record keeping and investigates any areas of concern relating to practice. The supervisor to midwife ratio was 1:15 which equalled the recommended ratio of supervisors to midwives.
- Four midwives felt further training was not accessible. They told us there was no allocation for training during their working day, and further career progression was only attainable if they attended courses in their own time.
- Maternity support workers were able to attend further training to enhance their skills.
- We were not sent specific appraisals attendance figures for midwives who worked at the maternity centre; however all of the midwives we spoke with told us they had received an appraisal within the last year. We saw in minutes from community managers meetings that staff were reminded to book appraisals with their managers.

# Maternity and gynaecology

### Multidisciplinary working

- Midwives of all grades told us they were proud of their team working.
- They reported good working relationships with the Consultants who ran ante natal clinics at Andover War Memorial hospital.
- Midwives worked closely with the community midwives and reported good relationships with most of the GPs in their locality.

### Seven-day services

- The maternity centre offered routine ante natal and post-natal care seven days a week.
- Women could access the service for delivery of their babies out of hours. Midwives operated an on-call system and were contacted by labour line if they were required to attend the maternity centre out of hours.
- There is no pharmacy department at Andover War Memorial Hospital. They do have a clinical pharmacy service and a pharmacy technician visits three times a week and a pharmacist one day a week.

### Access to information

- Pregnant women carried their own records. These were used by all clinicians involved with the woman's care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for their post-natal care.
- Medical records were created in the form of the 'red book' for each baby.
- Records of information given and received via labour line were recorded. Information was sent via secure email to midwives at the maternity centre if women had been requested to attend.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Throughout our visit staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- One woman we spoke with told us "everything has been explained to me" and the midwives "asked my permission" before checking the position of her baby.

## Are maternity and gynaecology services caring?

Good

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

We rated caring as 'good'.

Feedback from women and relatives about their care and treatment was consistently positive. We observed women were treated with kindness, compassion and dignity throughout our visit.

Women told us they felt involved with their care, and had their wishes respected and understood. All women had a named midwife to improve the continuity of care, communication, information and advice.

The CQC Maternity survey showed the trust was performing about the same as other trusts.

Staff helped people and those close to them to cope emotionally with their care and treatment.

### Compassionate care

- We spoke with four women who had used the service for routine ante natal and post-natal care. None of the women had chosen to deliver their babies at the unit. The women told us all the midwives were "lovely". One woman told us the midwives were "fantastic" and she felt able to talk to them "about anything".
- We observed staff caring for the partner of a woman who had been in labour overnight. They took time to ensure he had taken some rest and had enough to eat and drink.
- The centre displayed their friends and family test results. Recent results showed that five women had responded to the test and all of the women said they would recommend the service to their friends and family.
- Positive feedback was displayed in the waiting area. Comments included "really good service", "friendly staff, clean environment" and "the knowledge and support I have received has been great and has helped me to feel confident that I am going to get the best care".

# Maternity and gynaecology

**Understanding and involvement of patients and those close to them**

- Women told us they were given sufficient time to ask questions and had enough information about their care.
- All the women told us they had a named midwife and this was documented, along with the midwives contact details, in the front of their hand held notes. This was to ensure women were able to contact their midwife if they required further information or advice.
- Women attended confident birthing sessions to enable them prepare for childbirth at the maternity centre.

**Emotional support**

- Women had access to specialist perinatal midwives to enable them to discuss any anxieties about giving birth.
- Assessments were undertaken to detect if women required further support for mental health needs.

## Are maternity and gynaecology services responsive?

Good

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

We rated responsive as 'good'.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Women were able to choose the most appropriate place to receive their ante-natal care. This included at their homes, at their GP practice or at the Maternity Centre at Andover War Memorial Hospital.

Labour line midwives were based at the local ambulance operations centre. They gave advice and support to women in labour and were able to prioritise ambulances to women in labour if they were considered an emergency.

The birth rate at the maternity centre was low and women had good access to services. There was a one stop' hysteroscopy clinic for women attending gynaecological appointments.

Women had access to sufficient information to support them with their pregnancy options. Women had access to telephone translation services and staff told us information could be sourced in other languages if required.

Complaints were handled appropriately and the learning was used to improve the service.

**Service planning and delivery to meet the needs of local people**

- Pregnant women were able to choose to have their routine ante-natal and post-natal care at the Maternity unit. Women told us it was easier to park and closer to their homes.
- The unit was staffed by midwives and maternity support workers between the hours of 8am to 5pm every day.
- Pregnant women were able to call the labour line midwives based at the local ambulance operations centre for further advice. The midwife discussed their birth plan and made arrangements for their birth and ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners if their chosen location for birth was stretched to capacity. Midwives told us that it was unusual for a woman not to be able to give birth in her chosen place. Labour line midwives were able to prioritise ambulances to women in labour if they were considered an emergency.
- Systems were in place to review service plans to meet the needs of local people. For example the Maternity Services Liaison Committee (MSLC). The MSLC was attended by members of the public and local maternity commissioners. The chair of the MSLC told us they had been asked for their views and feedback with regards to future plans for the service and had used social media to gain feedback from women about the current services on offer.

**Access and flow**

- Women had streamlined access to ante-natal services. Once a booking form had been received at the maternity unit an automatic scan and blood appointment was sent to the women's preferred ante natal clinic. Daily blood test results were sent to the

maternity service and high risk results reviewed by a screening midwife. Women with high risk test results were offered face to face appointments for further tests if required.
- Women due to give birth were able to visit the service out of hours after an initial phone call to labour line.
- The birth rate at the Maternity Centre was low and women had good access to services.
- The centre had to close approximately three years ago due to staffing pressures in Basingstoke and North Hampshire Hospital maternity unit and the Royal Hampshire County Hospital maternity unit. Staff redeployed to these two hospitals. The Maternity Centre re-opened in 2012. However midwives felt that the wider community did not realise the maternity centre was open and as a consequence their attendance rate remained low. Midwives throughout the trust encouraged appropriate pregnant women to consider delivering their babies at the maternity centre
- Patients who attended for gynaecological appointments were able to have their treatment on the same day. Women were able to attend a 'one stop' hysteroscopy clinic. Women were seen as outpatients, and if required were able to have their treatment on the same day.

**Meeting people's individual needs**

- In order to access the centre during the day, women were required to press a buzzer and wait to be allowed access. During one of our visits the centre was busy and one woman waited six minutes before a midwife arrived to open the door. The woman told us staff usually answered the door promptly, however there had been two times when she had been required to "wait a long time" before the door was opened.
- A wide variety of leaflets were displayed on topics such as breast feeding, bump yoga and nutrition. Some of the leaflets were available in other languages if required.
- Booklets were provided for women by the trust in line with NICE guidelines. The booklets contained information about the three care settings that were available Basingstoke and North Hampshire Hospital, The Royal County Hospital in Winchester and the midwife led Maternity Centre at Andover War Memorial Hospital.

**Learning from complaints and concerns**

- Complaint information leaflets were available in patient areas.
- Complaints were handled appropriately and action was taken as a result of complaints and concerns. "You said / we did" boards were displayed in the waiting room to inform visitors about learning from complaints and concerns. We read that one woman had complained about the attitude of a member of staff. The member of staff was spoken with and an apology was issued to the complainant.

## Are maternity and gynaecology services well-led?

Good

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

We rated well led as "good."

There was a clear statement of values driven by quality and safety. There was a strategy and vision for the service which was focused towards the development of a new hospital. Staff and the members of the community had been consulted about the changes to service provision and had been involved in the architectural design of the new building. Short term plans had been developed to ensure staff were ready for the move and guidelines were embedded across the sites. However, there was not a specific strategy or plans for the maternity centre in the short and medium term. The overall plan was for the service to remain open to increase choice for women but the plans to increase birth rates or expand and develop the service were not developed.

There were comprehensive risk, quality and governance structures and systems were in place to share information and learning. Staff across the service described an open culture and felt well supported by their managers. Staff continually told us they felt "proud" to work for the trust and that their successes had been acknowledged and praised by the trust board.

The development of labour line in partnership with South Central Ambulance Service NHS foundation Trust was the first of type in the country. There were plans to develop the service further to provide cross county work. Labour Line

had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they had also been awarded second place in the Midwifery Service of the Year Award

### Vision and strategy for this service

- All staff we spoke with were aware of the trust wide values and were able to describe them to us. These were designed to form the acronym CARE and were compassion, accountability, respect and encouraging.
- The trust had produced a clinical strategy for maternity and women's health. The strategy detailed plans for the future development of the service within the proposed new critical treatment hospital. The new treatment hospital was to be built on a new site between the two main hospitals in the trust. The vision was to create midwifery led care at Basingstoke and North Hampshire hospital and the Royal County Hospital. A further midwifery led unit alongside Obstetrician led care was proposed for the new site. In addition the new critical treatment centre would have facilities for gynaecological care. Gynaecology services would also remain at the two existing sites.
- There were not specific plans for the Maternity Centre or plans should the new hospital not go ahead or be delayed. Staff told us the overall plan was to continue to increase birth rates and midwives told us the maternity centre would remain open to facilitate a choice for women across the county.

### Governance, risk management and quality measurement

- Specialist risk midwives were employed to assess risks to care delivery within the service. Maternity risks were discussed at the monthly risk management forum attended by a variety of staff including consultants, midwives, anaesthetists and students. The forum consisted of case presentation and discussion to facilitate learning from incidents, risks and complaints.
- Monthly maternity risk reports documented incidents recorded across all three trust sites. Monthly staff meetings were held to discuss incidents and any other areas of concern.
- Senior managers demonstrated an understanding of the current service risks. There was a dedicated risk register for the maternity service. The highest risk was the correct interpretation of CTG traces. Other risks included the availability of a second theatres team and damaged sinks in the labour ward, both at the other trust sites. There were no documented risks for the maternity centre. There was a dedicated risk manager for the service who worked across all sites in the trust. The manager demonstrated an awareness of the risks and subsequent action plans to reduce further risks. We saw from minutes of meetings that all risks and incidents were presented at risk meetings and learning was shared across the trust.

### Leadership of the service

- All of the staff we spoke with were positive about their relationships with senior and immediate managers. Two of the midwives told us they thought some members of the trust board were "unaware of what we do"
- Senior managers spoke passionately about the staff. They told us they were "very proud" of their teams and demonstrated they had a clear understanding of the concerns midwives and nurses had on a day to day basis. For example they understood concerns regarding staffing levels within the maternity service. They had held meetings across the trust to talk to staff about their concerns and plans for further recruitment. We saw from minutes of the meetings that staff had been able to discuss areas of concern and action plans had been produced to address these.

### Culture within the service

- All staff told us they felt confident their concerns would be listened to, and honesty and openness was encouraged.
- During our visit we observed staff interactions with each other and managers. We saw that staff treated each other with respect and they were able to speak freely with managers.
- Two midwives told us they felt although the birth rate was low; they spent a significant amount of time on ante natal and post-natal checks and advice. They felt their level of activity was not accurately recorded which resulted in them often being required to work at the other maternity units in the trust.

### Public engagement

- The Maternity Service Liaison Committee (MSLC) represented women who had used the maternity service. They met 10 times a year. The chair of the committee told us they were involved in the work as to whether partners could stay over and had meetings with

architects with regards to service provision and design for the new hospital. Social media was used to gather feedback from women and surveys were conducted to ensure the views of women who used the service were taken into account.
- Staff had held open days to encourage women to visit the centre. We saw posters encouraging women to visit the centre and talk about birth options and "eat lots of cake".

**Staff engagement**

- Staff had been consulted about the future development of the service trust wide.

**Innovation, improvement and sustainability**

- The development of labour line in partnership with South Central Ambulance Service NHS Foundation Trust was the first of type in the country. Midwives work side by side with ambulance colleagues to provide telephone support to women in the early stages of labour. The continuity of care and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour. Labour Line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they had also been awarded second place in the Midwifery Service of the Year Award. There were plans to develop the service further to provide cross county work. Senior managers told us other Trusts were considering developing this service and they would provide support and guidance if required.
- Senior staff told us they would like to further expand the service provided at the maternity centre, to include an early pregnancy advice unit.

# End of life care

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Outstanding |
| Responsive | Good |
| Well-led | Outstanding |
| Overall | Outstanding |

## Information about the service

Hampshire Hospitals NHS Foundation Trust serves a population of approximately 600,000 across Hampshire and parts of West Berkshire. Between January and December 2014 there were 1,433 in-hospital deaths across Hampshire Hospitals NHS Foundation Trust.

Andover War Memorial Hospital is part of Hampshire Hospitals NHS Foundation Trust, and forms part of the cancer services unit of the surgical services division. End of life care is provided on the Countess of Brecknock Hospice, a six-bedded facility that provided specialist palliative care. Where end of life care is provided on the inpatient medical ward at this hospital, support is provided by the specialist palliative care team.

The Hampshire Hospitals palliative care service is formed of two specialist palliative care multidisciplinary teams (SPC MDT). The North Hampshire SPC MDT covering The Basingstoke and North Hampshire Hospital and, the community of North Hampshire and, the Winchester and Andover SPC MDT covering, The Royal Hampshire County Hospital, Andover War Memorial Hospital, Andover community and The Countess of Brecknock Hospice. Both teams include; palliative care consultants, specialist palliative care nurses, physiotherapists, occupational therapists, a counsellor, bereavement services, a specialist palliative care pharmacist and, an end of life facilitator.

During our inspection we spoke with five patients, two relatives and 12 staff, including staff nurses, a health care assistant, ward sisters, an occupational therapy assistant, members of the specialist palliative care team, the end of life facilitator, a bereavement officer and a member of the chaplaincy team. We observed interactions between patients, their relatives and staff, considered the environment, and looked at two 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and two medical and nursing care records. Before our inspection, we reviewed performance information from, and about, the hospital.

# End of life care

## Summary of findings

End of life care at this hospice was "outstanding". We rated the service good for safe, effective and responsive care and outstanding for caring and well-led care.

People were protected from avoidable harm and abuse. There were reliable systems and processes were to ensure the delivery of safe care.

Care and treatment was delivered in line with local and national guidance and, a holistic patient-centred approach was evident.

There was good multidisciplinary working, staff were appropriately qualified and had good access to a comprehensive training programme dedicated to end of life care.

Patient outcomes were routinely monitored and where these were lower than expected, comprehensive plans had been put in place to improve. 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms had been completed.

Staff treated people with compassion, kindness, dignity and respect and feedback from patients and their families were consistently positive.

People's needs were mostly met through the way end of life care was organised and delivered. However, the rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way. Where delays to discharge had occurred, these were mostly subject to circumstances outside the control of the trust.

The leadership for end of life care was strong. There were robust governance arrangements and an engaged staff culture all of which contributed to driving and improving the delivery of high quality person-centred care.

This was an innovative service with a clear vision and a strong focus on patient centred care, and was supported by a board structure that believed in the importance of good end of life care for the local population.

## Are end of life care services safe?

Good

**By safe we mean that people were protected from abuse and avoidable harm.**

We rated safe as 'good'

Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Where incidents had been raised, actions were taken to improve processes.

Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. Staff demonstrated a good understanding of the early identification of a deteriorating patient. Monitoring of risks to patients was mostly positive with actions considered to minimise future risks.

We saw elements of good practice including good infection prevention and control practice, safe management of medicines and the safe management of patient records.

Safeguarding vulnerable adults was given sufficient priority, and staff took a proactive approach to the early identification of safeguarding concerns.

Nursing and medical staff were appropriately trained, and staffing levels were such that patients received safe care and treatment. There were appropriate arrangements for out of hours cover.

### Incidents

- Incidents were reported through the trust's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. Staff were encouraged to report incidents.
- Between October 2014 and April 2015, the hospice reported 19 incidents: ten community acquired pressure ulcers, eight falls and one information technology failure. We saw where incidents had been reviewed and action taken. For example, a new nurse call system with a falls alarm had been introduced.

# End of life care

- The hospice undertook a weekly community virtual palliative care round, attended by the hospice occupational therapy assistant. This facilitated rapid access to equipment for patients at home.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting system. Senior staff we spoke with were aware of duty of candour and talked about the importance of being open and transparent with patients and their families.

**Safety thermometer**

- The hospice monitored the incidence of pressure ulcers, falls with harm, catheter associated urinary tract infections (CUTI) and venous thromboembolism (VTE) through the use of the NHS safety thermometer. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. This enables teams to measure, assess, learn and improve the safety of the care they provide.
- Safety thermometer data for the period September 2014 to May 2015 showed harm free care had been delivered in six out of nine months. Where harm had occurred this was due to a CUTI or, VTE. Data we reviewed before our inspection showed a high level of patient harm on two occasions. However where a CUTI had occurred, this was in one out of only two patients present on the hospice ward area and where a VTE had occurred this was one out of five patients present on the hospice ward area.
- Where actions were required as a result of the findings the sister told us they would consider the needs of the patient in the first instance. For example, a patient with an identified CUTI did not have their urinary catheter removed because, it was felt, this would cause more distress to the patient. This had been discussed and agreed with the trust infection control team.
- Safety thermometer information was not publicly displayed. This meant patients and the public could not see how the hospice was performing in relation to patient safety. The nursing sister told us data was not displayed because they wanted the hospice environment to be as non-clinical as possible.

**Cleanliness, infection control and hygiene**

- The Countess of Brecknock Hospice was clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. The hospice had been refurbished in 2014 and reopened following infection control environmental assessment and approval. In May 2015 an environmental audit carried out at the hospice showed the level of cleanliness to be 98%.
- Throughout the hospice, we observed all staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash their hands or use hand sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. All staff were observed to be adhering to the dress code, which was to be 'bare below elbows'. Hand hygiene audit results for April 2015 were reported to be 100%.

**Environment and equipment**

- The trust used syringe pumps for end of life patients who required a continuous infusion to control their pain. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication, because the syringe drivers used were tamperproof and had the recommended alarm features.
- A wireless nurse call system had been introduced following the refurbishment of the hospice in 2014. Individual pagers alerted staff to the patient requiring assistance. The hospice sister told us that this eliminated the traditional call bell noise. This allowed them to monitor the number of nurse contacts the patients were requiring, and was useful when feeding back to relatives regarding the amount of assistance a patient may have required during a shift.

# End of life care

### Medicines

- Medicines were stored safely at the hospice. We looked at the clinic room where medicines were stored and found that the medicines fridge temperature was monitored and recorded regularly.
- We reviewed the storage and administration of controlled drugs. (Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation). They were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and there was evidence that these were regularly checked.
- The trust had standard operating procedures for the prescribing of 'anticipatory medicines', medicines prescribed for the key symptoms in the dying phase (ie pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness). We reviewed two medical and nursing case notes of those patients identified as being in the last hours or days of life. We saw where anticipatory medications were prescribed appropriately.

### Records

- Patients 'achieving priorities of care' (APoC) documentation was stored at the patient's bedside. This allowed for ease of access for the multidisciplinary team, patients and their relatives.
- During our inspection we saw medical notes for end of life patients were stored securely in the main office of the hospice.
- We reviewed the medical and nursing notes for two patients who were receiving end of life care. The notes were accurate, complete, legible and up to date.

### Safeguarding

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. One member of staff we spoke with could recall a recent safeguarding incident regarding an end of life care patient. The incident involved a patient who reported to staff that their spouse had been 'unpleasant' to them. A safeguarding alert had been appropriately raised in this instance.
- Information received following our inspection showed the overall uptake of adult safeguarding training at the hospice to be in line with the trust target at 80% (16 out of 20 staff).

### Mandatory training

- Nursing, medical and therapy staff we spoke with at the hospice reported having good access to mandatory training and most staff told us they were up to date. Mandatory training included infection control; information governance; manual handling; basic life support; conflict resolution; equality and diversity; fire safety and health and safety. The trust target for staff uptake of mandatory training was 80%. We saw an average uptake of mandatory training for staff working at the hospice of 78% across all eight subject areas.

### Assessing and responding to patient risk

- We reviewed the nursing notes of two patients identified as being in the last hours or days of life. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Braden Scale. Risk assessments for patients were completed appropriately on admission and reviewed at the required frequency to minimise risk.
- Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. At the time of our inspection all the patients were identified as being in the dying phase of their illness and as such, physiological observations were not recorded. Where patients physiological observations were recorded staff told us the consultant would complete a treatment escalation plan. Treatment escalation plans outlined the level of intervention required should the patient's condition deteriorate.

### Nursing staffing

- We were not made aware of how staffing levels were calculated. None of the nursing staff we spoke with raised concerns about the level of staff available at the hospice.
- The inpatient area of the hospice was staffed with two trained nurses and two healthcare assistants (HCA) during the day, in addition to the hospice sister and two trained nurses and one HCA at night. The hospice sister

# End of life care

reported 1.9 whole time equivalent (WTE) band five nurse vacancies and told us recruitment was currently underway. We saw where actual staffing levels met planned staffing levels.

- The service was also in the process of increasing the nursing establishment to support the hospice at home service. At the time of our inspection the hospice at home service was staffed with nurses from the inpatient area.

### Medical staffing

- Day to day medical cover at the hospice was provided by local GPs. Due to an increase in GP workloads this provision was due to end the week of our inspection. From 1 August 2015 a 'trust-grade' (a doctor who has reached a certain level in training and stayed working at that level) and a specialty doctor (a doctor with at least four years of postgraduate training, two of those being in a relevant specialty) had been employed by the trust.
- Telephone support out of hours was provided by one of four palliative care consultants and the hospice at home service.

### Major incident awareness and training

- The trust had suitable major incident plans in place. A major incident policy was in place for all trust staff and outlined how Hampshire Hospitals NHS Foundation Trust would respond in the event of an emergency (major incident). Major Incident training was included on the trust corporate Induction and in the local induction for all new staff.
- All staff were familiar with the major incident policy and had access to the policy both electronically and in hard copy. Business continuity plans were in place should there be any disruption to the day to day running of the service.
- Any specific issues or risks that could be predicted were raised at the monthly divisional performance review meeting via the divisional and medical directors.

## Are end of life care services effective?

Good

**By effective, we mean that people's care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence.**

We rated effective as "good".

In response to the 2013 review of the Liverpool Care Pathway (LCP), the trust had developed the patient-centred 'achieving priorities of care' (APoC) documentation. Evidence based assessment, care and treatment was delivered in line with national guidance and the National Institute for Health and Care Excellence (NICE) quality standards and local guidelines were in place. These were followed for the effective management of the five key symptoms at the end of life.

Patient's symptoms of pain were appropriately managed and staff actively monitored the patient's food and fluid intake. Patient outcomes were routinely monitored and we observed comprehensive plans had been put in place to improve outcomes for patients.

There was good access to the specialist palliative care team with seven-day availability and staff were suitably trained to deliver end of life care.

We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.

Local audits demonstrated poor compliance with the implementation of the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders however; there were plans in place to raise awareness of DNACPR at local teaching sessions. During our inspection we reviewed two DNACPR forms. Our review showed both DNACPR forms had been fully completed.

### Evidence-based care and treatment

- Between April 2014 and April 2015, 1,886 patients had been referred to the specialist palliative care team. Of these, two thirds had a cancer diagnosis.
- Patient needs were assessed and care and treatment was based on National Institute for Health and Care

Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness.

- NICE quality standard 13 was followed in relation to end of life care for adults. We saw where the trust had benchmarked against NICE Standards for end of life care with most quality standards met.
- A review of two medical and nursing records showed symptom control for end of life patients had been managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- All staff reported having access to the Wessex Palliative Care Handbook of clinical guidelines (2014) and felt it was a good reference should they require guidance in end of life and palliative care delivery.
- Care after death was managed in accordance with local policies, guidance from the National End of Life Care Programme and the National Nurse Consultant Group (Palliative Care).
- In response to the 2013 review of the Liverpool Care Pathway the trust had developed the 'achieving priorities of care' (APoC) documentation. This document guided delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate.
- A plan for auditing the use of the APoC documentation at the trust had been designed. 10 forms from each hospital had been audited every quarter. The results had been discussed with the trust end of life strategy group. Results from July to September 2014, during the pilot stage of the APoC documentation, showed between 50% and 75% of the document had been completed appropriately.
- The trust had trialled the use of the AMBER care bundle. The AMBER care bundle is a simple approach used in hospitals when medical staff are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery; while talking openly about people's wishes and putting plans in place should the worst happen. The clinical lead for end of life care told us AMBER had not been successful at the trust. It was felt, that the limitation of a prognosis of one to two months for AMBER did not advocate advanced care planning (ACP) discussions for all patients and as such, alternative treatment escalation plans were in place. Treatment escalation plans outlined the level of intervention required should the patient's condition deteriorate.

**Pain relief**

- Patients we spoke with had been asked about their pain and given pain relief where appropriate at regular intervals. All staff were pro-active in managing patient's pain. We reviewed two nursing records for patients in the last days of life and saw where pain assessments were included in the 'achieving priorities of care' (APoC) documentation.
- Procedures were available to guide medical and nursing staff in pain management with additional support from the specialist palliative care team. This ensured in the last hours or days of life there was no delay in responding to patient's symptoms as they occurred.
- An audit of anticipatory prescribing was undertaken by the hospice between March and July 2015. Results showed 82% of patients had regular opioids prescribed (opioids are medications that relieve pain) and 100% of patients had appropriate opioids prescribed on an 'as required' basis.

**Nutrition and hydration**

- We reviewed two nursing records for patients in the last days of life. We saw that patients were screened for malnutrition and the risk of malnutrition on admission to hospital using the malnutrition universal screening tool (MUST). Where interventions were required we saw these documented on the 'achieving priorities of care' (APoC) documentation.
- A food diary was kept for each patient. This allowed staff to determine if advice needed to be sought from the dietetics department and enabled nursing staff to update family on their relative's food intake.
- A kitchen was available at the hospice for preparing and reheating meals sent from the hospital's main kitchen and for preparing light meals or snacks. In the kitchen we saw a white board where nursing staff documented each individual patient's food and drink preferences.

# End of life care

- Relatives were encouraged to bring in food or drink for the patient or themselves. We saw where this was labelled with the patient's name and appropriately stored.

**Patient outcomes**

- The hospice was contributing data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set.
- The trust was participating in a research project led by Lancaster University. In support of this project and following a successful bid for funding from the Department of Health, the trust was in the process of recruiting 50 volunteer befrienders. The volunteers were to offer companionship to palliative and end of life patients in their own homes. The clinical lead for the service told us the trust was the only NHS provider in England that had been accepted to be part of this project.
- There were 450 in hospital deaths between January and March 2015; this number included 24 deaths in the Countess of Brecknock Hospice. The case notes of 122 (27%) of these patients were reviewed by senior doctors using the trust mortality matrix. Results from this audit were mostly positive, with 87% of consultants reporting that end of life care was managed appropriately, 88% of consultants felt the patient was reviewed by a consultant appropriately and 97% of consultants felt the patient's death was unavoidable. Following this audit, areas for improvement had been identified and fed back to the relevant staff. Examples included access to medical notes and identified 'gaps' in the medical documentation.

**Competent staff**

- The palliative care education steering group met monthly to discuss end of life training at the trust. Minutes from these meetings demonstrated where training had been put in place, for example 'achieving priorities of care' (APoC) education, 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) competency training and training plans for junior doctors.
- The palliative care service supported a comprehensive internal and external training programme to improve the awareness and quality of palliative care delivered by clinical staff at the hospital.
- Four palliative care study days were held per year, two for health care assistants (HCA) and two for registered nurses. The study days alternated between two hospital sites at the trust.
- End of life and palliative care training was delivered on both medical and nursing induction days. This included input from the chaplaincy and bereavement services. At the time of our inspection some members of the specialist palliative care team (SPCT) were delivering training for the new doctors due to commence employment at the trust in August 2015.
- 'Grand rounds' took place at the trust. Grand rounds are an important teaching tool and a ritual of medical education and inpatient care. They consist of presenting the medical problems and treatment of a particular patient to an audience of doctors, residents and medical students. The SPCT had, on occasions, been invited by a consultant to provide end of life training during these rounds. The General Medical Council 2015 national training survey showed local teaching at this trust to be similar to the England average.
- The SPCT had access to a range of external education courses relevant to their role. We saw where staff from the SPCT had recently attended for example, a palliative care conference, communication training and training around 'Do Not Attempt Cardio Pulmonary Resuscitation'.
- Nursing staff were competent to care for peripherally inserted central catheters (PICC or PIC line). PICC is a form of intravenous access that can be used for a prolonged period of time. This meant staff were able to manage and treat acutely unwell patients and those patients requiring long-term intravenous medicines.
- Nursing staff reported having had an appraisal in the last 12 months. The hospice sister told us 100% of appraisals had been completed for 2015/16. Within the specialist palliative care team 94% of staff had received an appraisal in the last 12 months.

# End of life care

**Multidisciplinary working**

- The specialist palliative care team (SPCT) worked closely with the community specialist palliative care team, local GP's and a nearby community trust to provide continuity of care throughout the patient's journey.
- A daily admissions meeting was held via video conference link between the Royal Hampshire County Hospital (RHCH) and the hospice. This meeting involved hospital SPCT, nursing staff from the hospice and Consultants. The meeting allowed a daily discussion of any patients requiring admission to the hospice, either from the community or from the hospital. It was also an opportunity to discuss any new referrals to the community team, hospice at home service (HAH) or SPCT who required urgent input or advice.
- The Winchester/Andover specialist palliative care group multidisciplinary team met weekly via video-conferencing facilities in RHCH and the hospice to discuss new patient referrals and, the care and management of existing patients known to the service.
- The trust was developing an electronic palliative care co-ordination system. Electronic Palliative Care Co-ordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care at the end of life. At the time of our inspection staff within the trust were made aware of those patients known to end of life and palliative care services through a 'tagging' system on the patients electronic care record. Key details regarding patient preferences were shared with external providers and GP's through a twice-weekly video conference.
- The hospice had an informal agreement with a local funeral directors to collect the deceased's body. Where a deceased patient had a notifiable disease, had been referred to the coroner or a post-mortem was required, the funeral director would transport the body to the mortuary at the Royal Hampshire County Hospital.
- Patients, relatives, nursing and medical staff were aware who had overall responsibility for each individual's care. We saw a board in each patient's room that named the nurse and consultant responsible for the patient's care.
- Those patients with a confirmed diagnosis of heart failure, who were anticipated to be in the last 12 months of life, were referred to the cardiac palliative care clinic to be seen by a cardiac failure clinical nurse specialist and a Palliative care consultant.
- An end of life facilitator supported the SPCT, working 24 hours per week over four days. The end of life facilitator managed the bereavement office, looked at concerns and comments for themes, was involved in audits specific to end of life care and played an active role in arranging education sessions for staff.

**Seven-day services**

- The specialist palliative care team were available seven days a week from 9-5pm. Telephone support out of hours was provided by one of four palliative care consultants and the hospice at home service.
- Mortuary services were available 8am to 4pm seven days a week with on-call cover out of hours.
- Chaplaincy services were available and covered all three hospital sites, 10am to 6pm Monday to Friday with on-call cover out of hours.
- There is no pharmacy department at Andover War Memorial Hospital. They do have a clinical pharmacy service and a pharmacy technician visits three times a week and a pharmacist one day a week.

**Access to information**

- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. For example, the hospice had an end of life resource box, there was good access to the specialist palliative care team and relevant guidance was available on the palliative care / end of life trust intranet.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We reviewed two medical and nursing records of patients in the last days of life. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and patients were supported to make decisions.
- A trust wide audit of DNACPR forms dated April 2015 showed 92% had a documented reason for DNACPR decision; 51% had been discussed with the patient; 84% were clearly timed, dated and signed; 96% where an appropriate person had made the DNACPR decision; 84% had been countersigned by a consultant within 48 hours; 70% had a DNACPR decision documented in the medical notes and 54% where there was a discussion with the patient or relative documented in the notes. Following this audit we were told the trust had plans to

include teaching sessions on the importance of DNACPR policy at the junior doctor's induction. A case based DNACPR presentation including case law was also to be included regularly at induction.

- During our inspection we reviewed two 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Our review showed both DNACPR forms had been fully completed.

## Are end of life care services caring?

Outstanding ☆

**By caring, we mean that staff involved and treated people with compassion, kindness, dignity and respect**.

We rated caring as "outstanding".

Staff involved and treated people with compassion, kindness, dignity and respect. Staff had had training to improve their communication skills and address patient concerns. Feedback from patients and their families were consistently positive and included many examples of where staff had gone "above and beyond" . All family members, including pets, were supported to visit or stay at the hospice and we saw where family activities including meal times were encouraged.

We observed a strong, person-centred culture. All staff were committed to providing compassionate care not only to patients but also to their families and post bereavement. Patients and their families were truly respected and valued as individuals and were empowered as partners in their care. Memorial evenings and events took place on a regular basis and relatives were urged to bring in personal items that were important to the patient.

Staff valued and respected the totality of both patients' needs and the needs of their families. We saw where patients' emotional, social and religious needs had been taken into account and were reflected in how their care was delivered. There was good access to the trust chaplaincy service for patients and their families. Emotionally, relatives were well supported by staff at the hospice, the specialist palliative care team and the chaplaincy department. Where relatives required further support, additional support was made available via external bereavement and counselling services.

### Compassionate care

- Feedback from patients and their relatives was consistently positive about the way staff treated them. All the staff valued the relationship between patients and their family. Relatives told us, as full-time carers, they had little time to relax or attend social gatherings with friends or family. On one occasion the hospice had encouraged a relative to use the hospice facilities to entertain their friends. We saw where all family members were encouraged to visit or stay at the hospice, this included children and family pets. On the day of our visit a family member had brought a puppy in to show their relative. Patients and their relatives were encouraged to eat together. Staff provided details of local food take away services and promoted the use of the family room to create a 'normal' family mealtime.
- Relatives repeatedly told us, "Staff go above and beyond" and gave us many examples of compassionate care. We were told where a patients room would be prepared, not only for the patient, but for relatives also. Iced water would be available, photo's would be placed on pillows and moved to ensure they were in the patients line of sight, chairs would be moved depending on which side the patient was lying and staff had been known to use their own transport to take relatives home.
- One patient had young children and wanted to be at home but needed assistance to manage their pain. The hospice had arranged for the patient to attend the hospice on a flexible basis depending on their need. On the day of our inspection the patient had arrived for the consultant ward round and the hospice sister told us that the time of arrival had been arranged around the children's activities for the day. The patient told us, "This place is amazing". During a period of time at home, the same patient told us, the hospice at home service had visited them every night for one and a half weeks to ensure their pain was appropriately under control and described the care as, "second to none".
- The night before our inspection we were told of a patient who had run out of their strong pain medicine. The patient was able to travel to the hospice to receive medicine for their pain. We were told by the patient that the hospice had offered to send a member of staff to the patient as part of the hospice at home service.
- Staff recognised and respected the emotional needs of bereaved relatives. We saw where staff at the hospice

would be alerted to a deceased patient through the use of a poster of a butterfly. Butterflies on stems were also positioned at the nurses' station. Staff told us this was a reminder to staff to maintain a calm and peaceful environment whilst the deceased patient remained at the hospice. It was also useful to inform those staff not regularly present in the clinical area that a patient had died.

- A member of staff from the hospice would ring the relatives of the deceased the day following a patient's death and a card marking the anniversary of the patient's death would be sent a year later. The hospice would also send a single yellow rose to the patient's funeral. The hospice sister told us feedback from relatives suggested this contact was gratefully received.
- The hospice hosted a remembrance evening "Light a life" at a local church. This took place the week before Christmas and staff told us, was very well attended.
- Throughout our inspection we observed patients and their families being treated with compassion, dignity and respect. We observed a consultant ward round where medical and nursing staff showed an awareness of the importance of treating patients and their families in a sensitive manner.
- In July 2015 we saw where six people had responded to the NHS Friends and Family Test. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Results from July 2015 showed 100% of people would be 'extremely likely' to recommend the hospice.
- In order to ensure that the quality of care given to patients at the end of their lives was constantly improved, a questionnaire about experiences of end of life care at the trust was given to bereaved relatives. Results from the January to March 2015 survey were positive and showed 97% of people thought their relatives were sometimes or always treated with respect and dignity; 95% of people thought their relatives sometimes or always had enough privacy and; 97% of people reported that their relative was sometimes or always looked after well.

**Understanding and involvement of patients and those close to them**

- Individual rooms were thoughtfully decorated and created a non-clinical environment. Bright, colourful quilts were in use and pictures, sourced from a local artist, were on the walls. White boards were on the walls. These were used by patients and relatives to record key details about the patient. For example we saw; family photos, what their likes and dislikes were and what music they like to listen to. Children were also encouraged to write on the board.
- Communication training, based on the 'Sage and Thyme' model was provided for all staff. The 'Sage and Thyme' model provided evidence based communication skills training to all levels of staff and gave a structured and quick approach for dealing with the concerns of patients and their family.

**Emotional support**

- Staff at the hospice offered emotional support in addition to the specialist palliative care team. The trust also had a chaplaincy service and counselling services if required. Support for carers, family and friends were provided by the chaplaincy and bereavement services.
- Nursing staff reported good access to the chaplaincy department. They knew the members of the chaplaincy staff by name and said someone from the chaplaincy team would visit the hospice at any time.
- Bereavement services offered two bereavement sessions based at the hospice. Where additional bereavement support was required contact numbers for external bereavement counselling services would be offered.

## Are end of life care services responsive?

Good

**By responsive, we mean that services were organised so that they met people's needs.**

We rated responsive as "good".

People's needs were mostly met through the way end of life care was organised and delivered.

The hospital had a hospice that delivered patient centred care in a timely way. The hospice at home service played an active part in ensuring treatment and support was available to patients and their families 24/7.

# End of life care

The needs and preferences of patients and their relatives were central to the planning and delivery of care at this hospice with most people achieving their preferred place of care/death.

There had been few formal complaints for the hospice. However, there was a good process for addressing concerns at the earliest opportunity to avoid escalation to a formal complaint and we saw, where concerns had been raised, these were considered and actions taken as a result.

The trust monitored rapid/fast-track discharges. Audit results were lower than the standards set by The National Framework for NHS Continuing Healthcare and NHS funded nursing Care (2012). However, recommendations and actions to address these audit results had been made and results had been discussed at board level.

**Service planning and delivery to meet the needs of local people**

- There were designated beds for patients receiving palliative care. The Countess of Brecknock Hospice had six single occupancy rooms. In addition to this a hospice-at-home service and day-hospice facilities were available.
- Facilities were available for relatives to stay close by. Relatives were offered the use of a family room or were able to stay in the room with their relative.
- Complementary therapy services, hair dressing and relaxation, including aromatherapy and massage were available at the day hospice.
- The hospice-at-home (HAH) service was an integrated community service that delivered care to those patients identified as being in the last days or hours of life. Care was provided from 10pm until 8am seven days a week by trained nurses and health care assistants from the hospice. Between January and May 2015 the HAH had been funded by commissioners of the service. At the time of our inspection the service was being funded by the trust whilst a decision regarding further funding was being made by the commissioners.
- From January to May 2015 there had been 46 referrals to the HAH service. Reasons for referral included administering of injections for pain relief, assessment, reassurance, verification of death and night support. Outcome data about the HAH service demonstrated a positive impact on other services with 13 hospital admissions prevented, 12 hospice admissions prevented and a 98% reduction in out of hours visits by GP's.
- The 'achieving priorities of care in last days and hours of life' (APoC) pathway documentation was commenced when the patient was recognised as likely to be in their last days or hours of life. Advanced care planning was included in this document. We reviewed two APoC documents and saw that patients' wishes in relation to their preferred place of care/death had been documented. Data provided by the trust for January to May 2015 showed where an average of 97% of patients had their preferred place of death achieved, with the months of February to May achieving 100%.
- Information about the needs of the local population was collected quarterly to inform the commissioners of the hospice how services were planned and delivered. Information included; the number and percentage of patients who died with an end of life care plan; the number and percentage of patients who wished to die at home and who did not achieve this and an analysis of the barriers as to why patients were not supported to die in their preferred place of choice.

**Meeting people's individual needs**

- The needs and preferences of patients and their relatives were central to the planning and delivery of care at this hospice. The hospice was flexible, providing choice and ensured continuity of care. The cardiac palliative care clinic ran monthly to see those patients with a confirmed diagnosis of heart failure who were anticipated to be in the last 12 months of life. The aims of this service included patient involvement in clinical decision making; to reduce unnecessary hospitalisation; to identify and improve achievement of preferred place of death; to provide and maintain optimum symptom control; to improve quality of life; to provide and signpost to appropriate psychosocial support and improve communication between all services and professionals involved in patient's care. 35 patients had been seen at the cardiac palliative care clinic between April 2013 and August 2014.
- 'Just in case' medication (JIC) leaflets were given to patients, relatives and carers when the patient was discharged from the hospice. This included information

regarding medicines that the patient would be discharged with. JIC medicines are medicines that may or may not be needed, but are kept in the patients home 'just in case' they need it.

- Bereavement packs included written information for bereaved family and friends and specific leaflets for children of the deceased were available at the hospice and through the bereavement service. Nursing staff told us leaflets could be made available in languages other than English if required.
- Interpreting services were available from the main Andover Hospital site. Staff demonstrated a good awareness of the language needs of the local community and told us the process they would follow should they require an interpreter.
- In May 2015 an environmental audit was carried out at the hospice. As part of this audit an assessment of the care provided to patients living with dementia was undertaken. Results for this hospice showed the level of care for those patients living with dementia to be 80%. This result was amongst the highest in the trust.

**Access and flow**

- Patients were admitted to the hospice from home, transferred from hospital and occasionally from the day hospice. Admissions could occur seven days a week from 8am-6pm. Where patients could not be supported at home by the hospice at home service or community nursing services, overnight, an admission to an acute trust would occur.
- Bed occupancy was between 74% and 88% for the months January to May 2015. It is generally accepted in acute trusts' that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- We received mixed feedback regarding fast track discharges. Fast track discharges take place when a patient has a rapidly deteriorating condition and is considered to be in the terminal phase of their illness. Nursing staff told us 'fast track' discharges could take between one and four days to arrange and how quickly the patient was discharged home depended upon how quickly continuing healthcare funds could be authorised and the level of care the patient would need. The National Framework for NHS Continuing Healthcare and NHS funded nursing care was published in 2007 and revised in 2012. This framework states people with a rapidly deteriorating condition should be "fast tracked" to receive NHS funded care in a place of their choice at the end of their life.
- The hospice at home service was able to provide short-term care to support an earlier discharge. In addition to this the hospice had its own equipment store where equipment would be 'loaned' out if required urgently. A physiotherapist, occupational therapist and occupational therapy assistant were available to assist in the discharge process.
- Nursing staff told us rapid discharge for those patients in the last days or hours of life could usually be arranged within 24 hours. Rapid end of life discharge documentation was available to provide guidance to the nursing staff. Copies of the document were placed into the end of life resource box available on the unit.
- A retrospective audit of all patients discharged, from either this hospice or the Royal Hampshire County Hospital, to their home under continuing health care 'fast track' funding was undertaken between March 2014 and March 2015. The National Framework for NHS Continuing Healthcare and NHS funded nursing Care (2012) standards are that 100% of patients referred to the specialist palliative care team (SPCT) for assessment of suitability of fast track funding are assessed within 24 hours and 90% of patients whose preferred place of death is at home are discharged within 48 hours of assessment with the correct level of care. Results from the audit showed 100% of referrals for 'fast track' assessment were seen and assessed by the SPCT within a 48-hour time frame and the average time from sign off to discharge was consistently between four and five days. We saw where these results had been discussed at the end of life strategy group meeting in May 2015. It was agreed at this meeting that, whilst most discharges were subject to delays outside the control of the trust, data would continue to be collected and results shared at this meeting.

**Learning from complaints and concerns**

- Between April 2014 and March 2015 the trust received 606 formal complaints, of these, one related to end of life care at this hospital. The complaint had been reviewed appropriately and responded to in a timely way. We saw where an apology had been given as a result of the complaint.

# End of life care

- The hospice sister told us they encouraged staff to aim, where possible, for local resolution to avoid a concern escalating to a formal complaint. We were told of one example where a patient had raised a concern because they felt the hospice were unaware and unprepared for their admission. As a result of this concern, a welcome pack that included key information about the hospice and a personalised welcome card were placed on the bed before a patient arrived.
- The clinical lead for end of life care was proactive in managing and learning from concerns and complaints. We were told where individual complainants would be contacted to ask if they would partake in a patient story teaching session. This had been delivered at the trust both as a taped recording and through a face-to-face session with nursing and medical staff and the complainant.

## Are end of life care services well-led?

Outstanding ☆

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

We rated well-led as "outstanding".

The strategy and supporting work streams and objectives of end of life care at this hospice were stretching, challenging and innovative. We saw where these were also achievable. An end of life strategy group promoted the end of life care agenda and advised the trust board on any future plans for end of life care. Representation from other services within the trust included elderly care and emergency medicine.

Senior staff worked closely with other organisations within the locality of the hospice to improve care outcomes. There were good working arrangements with commissioners and third party external providers which included, the Wessex palliative and end of life care network board, the North and West Hampshire Clinical Commissioning end of life groups and the Wessex Palliative Medicines Physicians group.

The leadership, governance and culture were used effectively to drive and improve the delivery of high quality person-centred care. The leadership for end of life care was strong and empowered all staff to strive to deliver the best possible service. The clinical lead was enthusiastic and proactive in driving forward the end of life agenda for the trust and there was good support from the chief nurse, chief executive and executive and non-executive directors of the board.

There were high levels of staff satisfaction. Staff were engaged and demonstrated commitment to delivering the end of life strategy for the trust. Staff were aware of the developments in end of life care and had a good understanding of how to drive the service forward. All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care.

There were robust governance arrangements in place and we saw evidence where quality, risk and performance processes were regularly reviewed and improved at both local and divisional level.

This was an innovative service with a clear vision and a strong focus on patient centred care and was supported by a board structure that believed in the importance of good end of life care for the local population.

### Vision and strategy for this service

- The trust's strategy for end of life care was "Living as well as possible, until you die", supported by the CARE values. Staff within the hospice were aware of the strategy and supported and demonstrated the trust values. The trust had identified eight work streams in order to ensure end of life care was delivered in accordance with this strategy. These included care in the last days and hours of life; care planning at the end of life; enhanced co-ordination of care; do not attempt cardio-pulmonary resuscitation decisions; care after death; organ donation; culture; communication; patient and carer experience and end of life education.
- The trust had an end of life strategy group chaired by the clinical lead for end of life care. The purpose of this group was to promote and drive the end of life care agenda forwards and advise the trust board on any future plans for end of life care. Meetings were held bi-monthly and included representation from other services within the trust including elderly care and emergency medicine. Minutes of these meetings demonstrated a strong focus on governance arrangements in end of life care with discussions around

the 'achieving priorities of care' (APoC) documentation, rapid end of life discharge, the bereavement survey and a review of complaints relating to end of life care. This group fed into the surgery services governance board.
- The trust specialist palliative care service met quarterly with a multidisciplinary attendance from doctors, allied health professionals, specialist palliative care nurses and representation from the social work department. Minutes from these meetings demonstrated a shared responsibility towards end of life care at the trust. Examples of items discussed included, seven-day working, the use of sedation and education and training. Where actions had been identified at these meetings, we saw where these had been completed.

**Governance, risk management and quality measurement**

- Staff received monthly health and safety bulletins. These were used to keep staff up to date with equipment, processes and procedures. We saw where sharps management, waste management and online learning management had been included in these bulletins.
- There was an effective governance framework to support the delivery of the end of life strategy at this trust. Quality, risks and performance issues for end of life care were monitored through the cancer and radiotherapy governance services framework. This group met quarterly and was chaired by the clinical lead for end of life care. We saw from minutes following these meetings, where a wide range of issues were covered including audit activity and results, patient feedback, staff training and finance.
- Locally, quality, risks and performance issues were monitored through the hospice clinical governance meetings. This group met bi-monthly and was accountable to the surgical governance board, through the cancer services business unit and the clinical director for cancer services. We saw, from minutes following these meetings, where a wide range of issues were covered including the last two months patient activity, deaths for discussion, complex cases for discussion, Incidents, concerns and complaints and an update on the hospice at home service.
- We saw where there were good working arrangements with commissioners and third party external providers. The clinical lead for end of life care met quarterly with the Wessex palliative and end of life care network board. Membership included palliative care leads and consultants from surrounding trusts, with representation from local clinical commissioning groups and county councils. The purpose of the group was to standardise and ensure best practice in the planning of palliative and end of life care across the Hampshire region. Consultants from the specialist palliative care team also represented the trust at The North and West Hampshire Clinical Commissioning end of life groups and the Wessex Palliative Medicines Physicians group.
- There was no separate risk register for end of life care. Risk registers were organised by the business unit and division. The cancer services unit, which included end of life care and surgical services division registers did not include any risks concerning the Countess of Brecknock Hospice.

**Leadership of service**

- Leadership within end of life care was strong, with clearly defined responsibilities for all staff responsible for delivering care. The clinical lead was enthusiastic and proactive in driving forward the end of life agenda for the trust and reported good support from the chief nurse, chief executive and executive and non-executive directors of the board.
- All the staff we spoke with felt their line managers and senior managers were approachable and supportive. They were all aware of the service lead for end of life care and reported good access to the lead and, the specialist palliative care team.
- All staff demonstrated a good awareness of developments within the service.

**Culture within the service**

- We saw effective team working at the hospice and an obvious mutual respect amongst staff. All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. We observed staff working well together and could see staff were supportive of each other.
- Staff were clearly committed to providing good end of life care at this trust. The 'starfish' campaign, a trust wide initiative designed to capture and share quality improvement, encouraged staff to write about small changes they were making to make a difference to patients and staff. Trust-wide, four examples relating to end of life care were received during March and April 2015. At the Countess of Brecknock Hospice a volunteer

had written about how they had assisted a dying patient achieve their wishes by witnessing their final will, this gave the patient and their family peace of mind and comfort at a very difficult time.

**Public engagement**

- In order to improve the services the trust provided to patients in their last days of life and their friends and/or relatives, questionnaires were handed out to recently bereaved people to ask them a number of questions about their experience and that of their relative.
- Relatives who had raised a concern or complaint relating to end of life care were invited to share their experiences at staff training days held by the specialist palliative care team.

**Staff engagement**

- Nursing staff told us of weekly emails from the chief executive (CEO). These were information-giving emails that updated staff on changes and developments within the trust. As part of the email there was an email link to the CEO. This allowed staff to anonymously contact the CEO if they had concerns about their service.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through a national award scheme. Nominations were received either from staff working at the trust or, from the public. We saw where individual staff and the hospice team as a whole had received either nominations or awards as part of this initiative.
- A local Hampshire awards scheme, the Pride of Andover Awards, awarded the health category to the hospice in September 2014. The nomination had been made by a person whose relative had been cared for by the hospice at home service.

**Innovation, improvement and sustainability**

- All staff within end of life services demonstrated a strong focus on improving the quality of care and people's experiences through a range of local and national audits, feedback questionnaires and, public involvement in teaching across the trust.
- The reliance on financial support for the hospice at home service had not impacted on care delivery. Staff were aware of the financial constraints and considered different ways of working to ensure the service continued. For example, the use of the wireless nurse call bell system reduced the amount of time staff were spending determining which patient required assistance and the use of volunteers throughout the hospice allowed nurses time to concentrate on their clinical duties.
- The end of life resource boxes were a practical solution to ensure clinical staff had easy access to the right information needed to support the care they were delivering and, complimented the support of the specialist palliative care team.
- Audit results throughout end of life care demonstrated a proactive approach to continuous learning and development of the service.
- Recognition of staff through the WOW awards and external recognition led to high levels of staff satisfaction throughout the service. Staff felt valued by the trust and motivated to provide an excellent service to end of life patients.
- Information received before the inspection and following discussions with the clinical lead for end of life care, demonstrated the strong commitment the board of directors had to this service.

# Outpatients and diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires improvement |
| Overall | Good |

## Information about the service

Andover War Memorial Hospital (AWMH) is part of Hampshire Hospitals NHS Foundation Trust provides outpatient and diagnostic imaging services for a wide range of medical and surgical clinics. Many of the same consultants run clinics at both AWMH and the Royal Hampshire County Hospital, Winchester.

Outpatient appointments were available from 8:30am to 5pm, Monday to Friday. The outpatient department at AWMH provided 10,890 new outpatient appointments and 32,707 follow up appointments in 2014.

The diagnostic imaging department was open from 9am to 5.00pm and offered plain film radiography, ultrasound and bone densitometry. There were no services available out of hours or at weekends. Patients presenting to the Minor Injuries Unit at the weekend, who required X-ray would transfer to another site for diagnostic imaging.

We spoke with 10 patients and 17 members of staff including nurses, consultants, phlebotomists, radiographers, health care assistants, administrators and managers. Throughout our inspection we reviewed trust policies and procedures, staff training records and audits and performance data. We looked at computerised records and online booking systems.

We attended focus groups and listening events, looked at the environment and at equipment being used. We observed care being provided.

## Summary of findings

The outpatient and diagnostic imaging services were good for providing safe, caring, responsive services, but required improvement to provide well-led services.

Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission.

The environments were visibly clean and staff followed infection control procedures. Equipment was well maintained and medicines were appropriately managed and stored. Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used. Patients were assessed and observations were performed, where appropriate. However, there was not a tool in use to identify patient's whose condition might deteriorate.

Nurse staffing levels were appropriate as there were few vacancies. Radiographer vacancies were higher and they reported a heavy workload. There was an ongoing recruitment plan.

There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in rheumatology and ophthalmology. However, there was not a local audit programme to monitor clinical standards. Staff had access to training and had annual supervision but did not have formal clinical supervision.

# Outpatients and diagnostic imaging

Staff followed consent procedures but did not have an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.

Patients consistently told us that they had experienced a good standard of care from staff across outpatients and diagnostic imaging services. We observed compassionate, caring interactions from nursing and radiography staff. Patients told us that they were included in the decision making regarding their care and treatment and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.

There was some evidence of service planning to meet people's needs. For example, the breast unit offered access to one stop clinics where patients could see a clinician, have a biopsy and see a radiologist if required. National waiting times were met for outpatient appointments, cancer referrals and treatment and diagnostic imaging. However, the trust had a higher number of cancelled clinics, many of which were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments. Some patients had long waiting times whilst waiting in clinic for diagnostic imaging, and there could be delays of up to an hour.

There was good support for patients with a learning disability or living with dementia. Patients whose first language might not be English had access to interpreters although some staff were not aware of how to access this service. The service received very few complaints and concerns were resolved locally. Staff were not aware of complaints across the trust or the learning from complaints.

The outpatient department had a strategy in development. There were plans to deliver, local consultant led services, including more one stop, nurse led and complex procedure clinics for outpatient services. Staff were not aware of how the strategy would develop in their departments and there were no immediate plans to tackle capacity issues and clinic cancellations. In diagnostic imaging there was an action plan planned to increase the skill mix of staff, the capacity of services and service integration across sites. This had had yet to be considered at divisional and trust board levels and interim actions were not specified.

Governance processes required further development in the outpatient department to monitor risks and quality although these were well developed in diagnostic imaging.

Staff were not clear about the overall vision and values of the trust, but told us that the patient experience and the provision of high quality care was their main concern. Staff identified a disconnect with local services and the wider trust. Many staff in outpatients did not see their service leads frequently and said that trust board members did not have a visible presence.

Nurses and radiographers spoke highly of their immediate line managers and told us they worked in strong, supportive teams which they valued. There were however, few examples of local innovation and improvement to services. In diagnostic imaging, a staff representative role was being introduced following to support and implement positive changes within the department that staff members themselves had recommended. Public and patient engagement occurred through feedback such as surveys and comment cards.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good

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

We rated safe as good.

Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission.

Infection control processes had been followed. The environment was visibly clean and well maintained, with all clinical areas providing hand-washing facilities and hand gels for patients and staff. Equipment in use was well maintained and had been regularly serviced. The resuscitation trolleys were checked daily and staff followed procedures to ensure that all equipment was in date. If a patient collapsed within outpatients or diagnostic imaging, an ambulance would be called.

Medicines were secured correctly and patient group directions (PGD), which allow trained non-medical staff to prescribe medicines, were in date where used appropriately. Staff compliance with mandatory training was good. Staff were appropriately trained, and had a good understanding of, safeguarding procedures. When children were seen within the department, there was a member of staff who had attained level three in paediatric safeguarding.

Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used. However, there was not a tool in use to identify patient's whose condition might deteriorate.

Nurse staffing levels were appropriate as there were few vacancies. Radiographer vacancies were higher and staff reported a heavy workload. There was an ongoing recruitment plan.

### Incidents

- In outpatient clinics and diagnostic imaging services, incidents were reported on the trust electronic reporting system. Staff felt confident with the process for reporting incidents and confirmed that feedback was disseminated during team meetings, to share learning and improve patient outcomes.
- There had been no serious incidents reported at Andover War Memorial Hospital between May 2014 and April 2015.
- In diagnostic imaging, reportable incidents around ionising radiation medical exposure (IR(ME)R) were reported to the trust's radiation protection team and to the Care Quality Commission under IR(ME)R guidelines. Radiographers told us that there was an open reporting culture in relation to incident reporting and that their line managers encouraged staff to report incidents where applicable. Between March 2014 and February 2015 the trust had reported incidents to the Care Quality Commission. The trust was not an outlier for diagnostic imaging, nuclear medicine or radiotherapy. The number of reports was within the expected range and was similar to other trusts when compared with the same level of activity.
- 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 ten 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 principal aim is to improve openness and transparency in the NHS.
- Staff did not have a clear understanding about Duty of Candour. There was no specific training offered to staff in relation to Duty of Candour. Staff however, could identify the need to be open and transparent about the care patients received and said they would raise any issues.

### Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic imaging areas were visibly clean.
- There was good evidence of trust infection control processes being adhered to. There was an infection

control team within the trust who visited departments and provided feedback in infection control performance. In addition to this, outpatients and diagnostic imaging nominated a staff member who conducted departmental infection control audits in hand hygiene, with compliance across both departments being between 90% and 100%. There were no notice boards in outpatient waiting areas and this information was not on public display.

- In all clinical areas there was good evidence of personal protective equipment (PPE), such as gloves and aprons being available and used appropriately by staff.
- Hand washing facilities were available in all clinical areas and hand gels were provided for staff and patients in all communal and clinical areas.

**Environment and equipment**

- All environments were well maintained.
- In the outpatient department there was a folder which listed all of the departmental equipment and the date when each piece of equipment was due to be re-tested. This indicated that all equipment was appropriately maintained and serviced. We looked at 12 pieces of equipment and the portable appliance testing was up to date.
- There was appropriate access to resuscitation equipment in each clinical area.
- The resuscitation trolleys in outpatients and diagnostic imaging had been checked daily and all the equipment was observed to be in date. The departments were considering introducing a 'grab bag' to replace the dated resuscitation trolley which would contain emergency supplies. In the event of an emergency at Andover War Memorial Hospital, an ambulance would be called.
- In diagnostic imaging there was signage to alert patients to potential radiation hazards in relevant areas.
- Radiation Protection check on equipment had been done very six months.

**Medicines**

- Medicine cupboards were locked and secure and drug fridges were checked and in order. Fridge temperatures were checked and recorded daily and were in line with national guidance.
- Prescription pads were stored securely in lockable drawers.
- There were no patient group directions in outpatients (PGD). In Ophthalmology, eye drops were prescribed by the consultants and administered by nursing staff. In diagnostic imaging, all PGD's were in date and in accordance with trust guidelines.

**Records**

- Outpatient notes were in paper form. Medical records staff brought the notes to outpatients and the nursing staff prepared them for clinics, ensuring all of the relevant paperwork was available for the consultation.
- In 2014/15, the trust identified that 0.4% of patients were seen without the full medical records being available. The availability of medical notes was on the outpatient and medical records risk register and issues had been raised by staff as incidents in the past. This issue had been placed on the divisional risk register. Action plans had been made to ensure the availability of patient notes for clinic appointments, and staff told us that the situation had improved within the last few months. Staff reported an average of one or two patient records missing per clinic. This had not been locally audited.
- If the medical notes were unavailable for clinic, a temporary set would be assembled with any diagnostic test results printed from the electronic patient record and inserted into the notes. This ensured that the consultant had all the relevant information necessary to effectively treat a patient.
- All the records that we reviewed during inspection were of a good standard, clearly written, and appropriately dated and file. Apart from one set of temporary notes, all the notes that were available for the clinics were full medical notes.
- Medical records were stored securely.

**Safeguarding**

- All staff within outpatients and diagnostic imaging had completed their level 2 safeguarding training. Where children were seen within the department, there was a clinician available who had completed their level 3 paediatric safeguarding.
- Staff knew how to report safeguarding concerns. They knew where to go for further advice on the trust intranet if required and had felt well supported by their line managers if they had encountered more complex safeguarding issues.

# Outpatients and diagnostic imaging

- In diagnostic imaging there was a safeguarding lead to whom radiographers could refer with any concerns.

**Mandatory training**

- Mandatory training included infection control, health and safety, fire safety and safeguarding. Training was available as e-learning, online, and within a face to face classroom environment.
- Mandatory training across outpatients and diagnostic imaging was up to date with a 95% - 100% compliance rate, against a trust target of 80%.
- Mandatory training was booked on the trust electronic system. Staff referred to the 'red, amber, green' colours which alerted them when their mandatory training was due to be renewed. Staff were able to book into available training slots and told us that they had no difficulty in being given time off to complete mandatory training.
- Line managers were alerted when a member of their team was on a 'red' colour for their mandatory training, which meant a subject was imminently due for renewal. This enabled them to monitor staffs' mandatory training compliance.

**Assessing and responding to patient risk**

- All staff understood the procedure to follow should a patient collapse or become acutely unwell in the outpatient or diagnostic imaging departments.
- In the outpatient and diagnostic imaging departments, Staff were told us that they would look at a patient's vital signs and record them in their notes. We observed that assessments and observations, where necessary, were recorded in the notes. The department did not use a tool, for example, the national early warning score, to identify patient's whose condition might deteriorate.
- Within the imaging department, patients were alerted by signs and information in waiting areas where radiation exposure would be taking place. There were also signs and posters to remind women who may be pregnant to inform the radiographer before their x-ray.
- The department had a Radiation Protection team. Staff at Andover referred to the Radiation Protection Supervisor at RHCH, to provide advice and ensure the requesting of X-rays is in line with IR(ME)R guidelines.

**Nursing/radiography staffing**

- In the outpatient department there were eight registered nurses (RN) and four health care assistants (HCA). There was one nurse vacancy for a RN. Recruitment was underway and candidates were due to be interviewed within weeks.
- Bank staff were used to fill gaps in staffing. Induction was thorough. New bank staff were initially supernumerary and had to complete a competency checklist before being able to work unsupported in clinical areas. No agency staff were used.
- In diagnostic imaging, staffing was a concern. There were six radiographer vacancies across the trust. There were some permanent staff in Andover but staff worked across Winchester and Andover to cover vacancies. Staff reported heavy workloads. Incident trends in May and June 2015 identified staff shortages to be the main cause of concern. A diagnostic imaging recruitment plan had been implemented and submitted to HR and finance.
- Diagnostic imaging services offered student radiographers placements, and they had previously recruited graduates who had been students within the department.

**Medical staffing**

- Senior Nursing staff told us that there were adequate levels of consultant cover for all clinic specialities.
- Consultant appointment times were allied to clinic times.
- Consultants confirmed good working relationships with junior doctors within the trust.

**Major incident awareness and training**

- Major incident awareness training was available to all new staff during the corporate induction programme.
- In the outpatient department there was a folder in the nurse's office where the major incident policy and responsibilities of the department were kept. The staff told us they would liaise directly with their line managers in the event of a major incident.
- There was evidence of business continuity plans in place both online and in line manager's offices which were to be referred to if a major incident was declared.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

**We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department**.

There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in rheumatology and ophthalmology. There was no evidence of a local audit programme in the outpatient or diagnostic imaging departments.

Most staff had received an annual appraisal and felt able to access relevant training to update their clinical skills specific to their roles. Students were offered placements with outpatients and diagnostic imaging teams. Health care assistants were also supported to train to become registered nurses. Staff, however, did not have formal clinical supervision.

There was good evidence of multidisciplinary team (MDT) working practices. Particularly in the breast unit and in cardiology.

Seven day outpatient services were not available at AWMH. Patients presenting to, for example, the Minor Injuries Unit at the weekend, may have to transfer to another site for diagnostic imaging.

Some had an understanding around consent procedures and how patients should be supported in every day practice. However, in the outpatient department, there was little understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests. The trust did not provide any specific training in relation to this.

### Evidence-based care and treatment

- Outpatient services took account of the relevant National Institute for Health and Care Excellence (NICE) guidelines to treat patients. We reviewed the clinical guidelines for rheumatology and ophthalmology. They both referred to NICE guidance.
- There was no evidence of a local audit programme in the outpatient or diagnostic imaging department.

### Patient outcomes

- The follow up to new appointment rate for Andover War Memorial Hospital was 2.7 to 3.7; the rate for England was 2.4 (January to December 2014)
- The breast unit is a fully integrated service which operates from the Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospitals. The unit also provides clinics at Andover War Memorial Hospital. The unit was participating in national audit. For example the National Cancer Intelligence Network Audit and the Breast Cancer Clinical Outcome Measures (BCCOM) audit.
- The breast unit provided data for the Somerset Cancer Registry database which was linked to the two week wait clinic auditing. As a result of evidence gained from the two week wait audits, the breast unit had changed practice to improve outcomes for patients, by providing an extra clinic to meet demand. The unit had also participated in peer review.

### Competent staff

- Most staff had completed an annual appraisal. 98% of outpatient staff had received their annual appraisal, 96% had completed their appraisal in diagnostic imaging. Where appraisals had not been completed, line managers provided evidence as to why they were outstanding, for example; where staff had been on maternity or long term sickness absence.
- The services had team meetings to discuss issues but staff did not have formal arrangements for supervision.
- All staff across outpatients and diagnostic imaging services felt that there were good opportunities to develop professionally by being offered training to update their skills and knowledge relevant to their post. Training was also available for staff who wanted to specialise, for example in diagnostic imaging. Radiographers were offered training to cover MRI and CT scanning.

# Outpatients and diagnostic imaging

- The trust encouraged a 'grow your own' ethos in relation to staff development. For example, health care assistants in outpatients told us that they had been offered the opportunity to study to become registered nurses.
- Radiography students told us that the training within the radiology team was very good.
- Nursing staff were generally aware of the requirements for revalidation and what their responsibilities were. They had received some information from the trust in relation to this.

**Multidisciplinary working**

- The breast unit held one stop clinics at Andover War Memorial Hospital. Staff told us that the multidisciplinary team (MDT) worked well. Nurses, radiographers, surgeons, radiologists and oncology specialists worked together to ensure that patients received the best possible care and treatment. Documentation confirmed well supported MDT meetings.
- All nursing staff across the outpatients department told us that they had good working relationships with the consultants from each speciality. They felt that ongoing communication with medical colleagues, improved a patient's experience within the department.
- In diagnostic imaging, staff told us they felt well supported by the radiologists. They felt part of a team where everyone recognised individual contributions to be important in ensuring that patients were given the best possible treatment.
- In cardiology an MDT meeting was held monthly to look at case audits. Evidence was seen of good multidisciplinary attendance at these meetings. Weekly echocardiogram meetings were also held with all echo tests being reported on.

**Seven-day services**

- Outpatient appointments were offered Monday to Friday 8:30am – 5:00pm.
- In diagnostic imaging, appointments were available Monday to Friday between 8:00am – 5:00pm.
- There were no services available out of hours or at weekends. Patients presenting to, for example, the Minor Injuries Unit at the weekend, may have to transfer to another site for diagnostic imaging. Staff also reported that there was a high number of repeat attenders to the MIU on Monday mornings because there was no radiology at the weekend.

**Access to information**

- Diagnostic test results were available online for clinicians to view during their consultations.
- If the full medical notes were missing for a patient during clinic, a temporary set would be compiled. A copy of the initial referral letter was scanned on to the Electronic Patient record and could be printed off for temporary notes. Copies of any additional clinical letters could be provided by the speciality secretary.
- There was an electronic, cross site imaging results facility. Clinicians could view imaging results on this system if they did not have a copy of the paper report.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Some staff had an understanding around consent procedures and how patients should be supported in every day practice. They used verbal consent appropriately and noted medical staff undertook consent for procedures.
- Staff did not have a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, to ensure decisions were taken in a person's best interest. There was no specific training provided by the trust in relation to this.

## Are outpatient and diagnostic imaging services caring?

Good

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

We rated caring as good.

Patients consistently told us that they had experienced a good standard of care from staff across outpatients and diagnostic imaging services. During inspection we observed compassionate, caring interactions from nursing and radiography staff. There were good examples of staff supporting patients during clinics.

# Outpatients and diagnostic imaging

Chaperone signs were displayed in waiting areas, and staff were observed asking patients respectfully if they required a chaperone during their consultations to protect their dignity.

Patients told us that they were included in the decision making regarding their care and treatment, and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.

There were quiet rooms available for patients who had been given bad news, and the trust chaplaincy service was available if required.

**Compassionate care**

- During our inspection the feedback we received from patients and the interactions we observed of care being provided, was consistently positive throughout. Patients continually told us that the care and treatment they had received while visiting outpatients and diagnostic imaging services had been of a good standard. One patient told us, 'I've been coming here for a long time, the care here is very good, it is a very friendly hospital'.
- We observed compassionate and caring interactions from nursing and radiography staff. Patients who were arriving for outpatient appointments were greeted warmly and this continued throughout their stay within the department. Staff provided a friendly, visible, person-centred approach toward the patients in their care.
- Chaperone signs were displayed across outpatient and diagnostic imaging waiting areas. Staff were observed asking patients if they required a chaperone during consultations.

**Understanding and involvement of patients and those close to them**

- All the patients we spoke to felt well informed and involved in the decision making regarding their care and treatment from start to finish.
- Staff told us about services for patients who required extra support to enable them to understand and be routinely involved in planning their own care and treatment. For example, the trust had an interpreter service for patients who did not speak English as their first language. Staff also told us about the learning disability nurse and of the process to contact her should a patient living with a learning disability attend for a clinic appointment.

**Emotional support**

- Staff demonstrated a good understanding of supporting patients who were in physical discomfort and took time to provide the additional care that these patients required.
- There were quiet rooms available for staff to take patients who had been given bad news and the trust chaplaincy service was available to support patients if required. If necessary, the chaplaincy service would contact other faith leaders to attend the department.

## Are outpatient and diagnostic imaging services responsive?

Good

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

We rated responsive as good.

There was some evidence of service planning to meet people's needs, for example, one stop clinics. The breast unit was an integrated trust service. Patients at Andover, were offered access to one stop clinics where patients could see a clinician, have a biopsy and see a radiologist if required and have a diagnosis. The breast unit had increased the number of clinics available to meet an increase in demand. There were also nurse led PUVA clinics. Following the initial GP referral, patients were able to arrange their own appointments to attend the clinic.

'Did not attend' rates were lower (better) than the England average and phone calls and texts were used to remind patients of appointments. The trust was meeting national waiting times for diagnostic imaging within six week, outpatient appointments within 18 weeks and cancer waiting times for urgent referral appointments within 2 weeks and diagnosis at one month and treatment within two months. The trust cancellation rate for appointments was 13%; the England average was 7%. Many of these clinic cancellations were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments.

# Outpatients and diagnostic imaging

There was good support for patients with a learning disability or living with dementia. Patients whose first language might not be English had access to interpreters although some staff were not aware of how to access this service.

Some patients had long waiting times whilst waiting in clinic for diagnostic imaging, and there could be delays of up to an hour.

The service received very few complaints and concerns were resolved locally. Staff were not aware of complaints across the trust or the learning from complaints.

**Service planning and delivery to meet the needs of local people**

- In outpatients, each speciality managed their own clinic lists. Outpatients as a department provided the nursing staff and room capacity to meet the needs of the clinic. There were one stop gynaecology, cataract and orthopaedic clinics.
- The breast unit offered access to one stop clinics. Appointments were offered to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by consultants. Patients who attended the one stop clinics, would see a clinician, have a biopsy taken and see a radiologist if required. If a cancer diagnosis was suspected, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options. This unit provided a responsive service for patients who were anxious in relation to a potential cancer diagnosis.
- The breast unit provided data for the Somerset Cancer Registry database which was linked to the two week wait clinic audit. As a result of evidence gained from the two week wait audits, the breast unit had changed practice to improve outcomes for patients, by providing an extra clinic to meet demand.
- A nurse led 'Psoralen combined with ultraviolet A' treatment (PUVA) clinic was held. Two members of nursing staff were trained to provide the service to patients. Following the initial GP referral, patients were then able to book their own appointments directly.
- There was one X-ray room at Andover which worked at full capacity. The diagnostic imaging service had an overall plan to increase capacity across the trust. There were not specific plans for the Andover clinic.

**Access and flow**

- In outpatient services, some patients used choose and book to arrange appointments, but managers could not identify what percentage of patient's used this method.
- In diagnostic imaging, electronic booking same day appointment facilities were available, which decreased the waiting times for patient's requiring more urgent review.
- 'Did not attend' rates were between 5.5% – 7% (January 2014 – December 2014); the England average was 7%. Phone calls and texts were used to remind patients of appointments.
- From April 2014 to March 2015, the hospital achieved the referral-to-treatment (RTT) standard for incomplete pathways (that is for 92% of patients to be on a waiting list for less than 18 weeks) in every month up to January 2015. The target was not met between January to March 2015.
- The national standards for cancer wait times were being met and the trust was consistently above the standard (April 2013 – December 2015). This included 93% of people whose first consultant appointment was within two weeks of a GP urgent referral; 96% of people who waited at most one month from a decision to treat to a first treatment for cancer; and 85% of people who waited at most two months from GP urgent referral to a first treatment for cancer wait clinics.
- Between January 2015 and April 2015 an average of 13% of outpatient appointments were cancelled each month by the Trust at Andover. The England average was 7%. The trust told us that this was primarily due to sickness, annual leave and study leave. A further 9% were cancelled by patients (the England Average was 6%). Some follow up appointments were booked up to 18 weeks in advance of the clinic date. This led to cancellations when clinical staff did not provide the six week notice period for leave requests. Evidence showed that a large proportion of these cancellations were given at short notice, with some patients being contacted on the day of the clinic to have their appointment rearranged.
- The trust aimed to offer all cancelled patients a new date at the time to avoid patients falling through the net. However, processes were being managed differently across the trust and some patients were missed. In ophthalmology and gastroenterology, for example, some patients had annual review appointments. Some

patient cancellations were waiting a significantly longer time for new appointment which could be up to 18 months to two years. During the additional waiting time, there would be the potential for a patient's condition to deteriorate. Staff could not identify the safeguards in place to ensure that this did not occur. There were plans in place to look at improving the cancellation of outpatient clinic appointments, but these were in development and currently only focussed on the outpatient services at Basingstoke and North Hampshire Hospital.

- In diagnostic imaging, between July 2013 and February 2015, overall less than 1.5% of patients experienced diagnostic waiting times of more than six weeks. The England average overall was 2.5%.
- In the outpatient department there was no data on how many patients waited over 30 minutes to see a clinician. There was one X-ray room at Andover hospital, which ran at full capacity daily, seeing between 78 – 90 patients. Staff told us that patients were often waiting for up to an hour for their X-rays. Patients were advised upon arrival if the clinic they were attending was running late. Nurses were also observed updating patients of any expected delay.

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**Meeting people's individual needs**

- The environment in outpatients was well maintained, with adequate seating arrangements for patients to sit and wait for appointments. In diagnostic imaging, the waiting area was small. There were not enough seats for patients to wait, and patients queued in corridors while waiting for their X-rays and scans.
- The waiting areas, consulting and imaging rooms were all wheelchair accessible.
- In clinical areas there was adequate provision to maintain a patient's privacy and dignity.
- Information leaflets were available, although all were in English and none were in easy read format. The trust had a translation and interpreter service. Interpreters were available over the telephone or would attend in person to support patients during their consultations. However, not all staff knew how to access these services.
- Staff told us about services for patients who required extra support to enable them to understand and be routinely involved in planning their own care and treatment. Staff also told us about the learning disability nurse and of the process to contact her should a patient living with a learning disability attend for a clinic appointment.
- Staff gave good examples of where reasonable adjustments were made for patients who were living with dementia. Dementia 'champions' had been trained and supported the outpatient team as a whole by providing advice and support when required. Nursing and radiography staff told us that if a patient was particularly distressed due to dementia, they would be prioritised in the clinic list.
- Nursing staff provided a good example of providing a responsive service to an unwell patient with additional support needs. When a stroke patient had attended by ambulance but the appointment had been cancelled, the nurse in charge of the clinic spoke with the consultant and the patient was prioritised, seen immediately and returned to their nursing home with the ambulance crew who brought the patient to hospital.
- Nursing staff followed an outpatient clinic plan for each speciality, this aided new staff in providing a seamless service for patients.

**Learning from complaints and concerns**

- Information on how to make a complaint was not displayed.
- Staff reported that there had been very few complaints to the service and could not recall any recently. If concerns were raised by patients staff described how the senior nurse would work to resolve the issue locally.
- In 2014/15, the outpatient department received four complaints, two were about cancelled appointments and two about absent medical records. There was one complaint in diagnostic imaging regarding treatment. These had been responded to appropriately.
- Across the trust the majority of speciality outpatient complaints were for cancelled appointments and waiting times. The staff at Andover, were not aware of these complaints or the learning to improve the service.
- Patient feedback was sought and welcomed across the trust. This feedback was obtained from patient surveys and comment cards. The comments were largely positive.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services well-led?

Requires improvement

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

We rated 'well-led' as requires improvement

The outpatient department had a strategy in development. There were plans to deliver, local consultant led services, including more one stop, nurse led and complex procedure clinics for outpatient services. Staff were not aware of how the strategy would develop in their departments and there were no immediate local plans to tackle capacity issues and clinic cancellations. In diagnostic imaging there was an action plan planned to increase the skill mix of staff, the capacity of services and service integration across sites. This had had yet to be considered at divisional and trust board levels and interim actions were not specified.

Governance processes in the outpatient department were at divisional level and were underdeveloped in the hospital. Information about incidents and patient experience was shared, but there was less information on clinical risk, complaints and audit to monitor the quality of the service and risks. Risks were collated at service and divisional level and the most serious, the availability of medical records, had been escalated to the trust board. However, the risk involving the cancellation of clinics was not monitored at local level. Governance processes in diagnostic imaging were well developed to manage risks and quality.

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Staff identified a disconnect with local services and the wider trust. Many staff in outpatients did not see their service leads frequently and said that trust board members did not have a visible presence.

Nurses and radiographers spoke highly of their immediate line managers. They told us that they felt well supported and valued. Staff said they enjoyed working for the trust due to the strong team support from colleagues.

There were no examples of local innovation and improvement to services. In diagnostic imaging, a staff representative role was being introduced to support and implement positive changes within the department that staff members themselves had recommended.

Public and patient engagement occurred through feedback such as surveys and comment cards.

### Vision and strategy for this service

- The outpatient service strategy was part of a clinical services review and was currently a set of proposals. The review was planned around the delivery of the a new critical treatment hospital. The review identified the need for general and locally based outpatient services which at Andover, Winchester and Basingstoke. The services would be consultant led with increased roles for advanced nurse practitioners. One Stop clinics and more complex procedures in outpatient clinics, as well as nurse led clinics, were proposed as part of the discussion. Referrals could come through A&E, Assessment Unit via GP, walk-in, referral and consultants would be responsible for triage to plan appoint bookings and pathways.
- The service had short term priorities. Managers told us that improving capacity was one of their greatest concerns and the need to improve the outpatient pathway. There was an action plan, in the very early stages of development, to improve the focussed on the number of cancelled appointments. The plan was being considered for implementation at Basingstoke and North Hampshire Hospital.
- The breast unit had fully integrated to provide a coordinated service across trust sites.
- Staff were not clear about any of the specific aspects of the trust wide strategy. However, most staff told us that their main vision for the service was continually improving the patient experience and providing high quality care.
- In diagnostic imaging there was a strategy to develop services which included a comprehensive action plan. The plan included developing radiographer assistants,

increasing capacity, developing education opportunities to develop and retain staff locally and integrated the diagnostic imaging service across sites. This strategy had yet to be agreed.

**Governance, risk management and quality measurement**

- The outpatient department held monthly performance review meetings to which all senior staff were invited. Governance issues were emailed out to all the outpatient staff which included patient experience outcomes. Information on clinical risks and complaints was not shared.
- Diagnostic imaging services held monthly cross site governance meetings. During these meetings radiation protection issues were discussed. Quarterly radiation protection meetings were held and the minutes from both meetings were disseminated to all staff by email. Staff told us that they felt they were kept up-to-date in relation to governance issues.
- The senior nursing staff, from all sites, met once monthly. The focus was incident reporting and learning from incidents. Evidence was seen in relation to these meetings and copies of the minutes were generally kept in the nurses' offices.
- The outpatients and diagnostic imaging departments had their own risk registers which formed part of the family and clinical support services division risk register. Risks were appropriately identified and mitigating actions were being taken. The highest risk was identified as medical records, had been escalated to the trust risk register. . The risk about cancelled clinics was not identified on the outpatient risk register.
- Risks specific to specialities were on the speciality risk register. There had been a serious incident requiring investigation of a patient lost to follow up at an ophthalmology clinic at RHCH, Winchester in February 2015. The patient's sight had deteriorated in the interim. The lessons learnt from this had not been shared at Andover and there had not been local actions to monitor patient's whose clinics were cancelled were appropriately followed up. There was no local data to review clinic cancellations.
- The services did not undertake local clinical audit.

**Leadership of service**

- The outpatient service had a band 6 nurse operational lead, and outpatient service manager lead and nurse manager lead. There was a superintendent lead in diagnostic imaging.
- Nurses and radiographers spoke highly of their immediate line managers. They continually told us that they felt well supported and valued. Staff felt confident that they could go to their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally.
- The staff in outpatients did not see the service manager lead regularly but did see the nurse manager lead.
- Most staff felt that the senior leadership of the trust did not have a strong, visible presence at Andover. Some staff had never met a member of the board and felt that Andover War Memorial Hospital had been 'forgotten' as it was so much smaller than the other two sites.
- In diagnostic imaging it was considered that from senior managers to board level there was a possible 'stumbling block' that prevented local development, autonomy and budgetary responsibility. This had curtailed local level management from implementing positive changes within the department, particularly in relation to staffing which would enhance staff morale and improve services for patients. The action plan agreed at local level had yet to be considered by the division and trust board level. Interim actions were not specified.
- It was evident that outpatients and diagnostic imaging had not fully integrated across the three trust sites, each site working quite differently despite the same leadership at senior management level. The local management recognised this and in diagnostic imaging there were plans in place which were seen during inspection, to move integration forward. This was not the case in outpatients. The breast unit however, had fully integrated and provided a unified service to all patients trust wide.

**Culture within the service**

- All of the staff we spoke to across outpatients and diagnostic imaging told us that the teams they worked in and the supportive relationships forged with their colleagues were the main reasons they enjoyed working for the trust.

# Outpatients and diagnostic imaging

- Most staff had been in post for a significant number of years and really felt part of the outpatients or diagnostic imaging team as well as part of the hospital.
- Staff told us they did not feel like part of the trust as a whole.
- Staff demonstrated at every opportunity that their patients and the provision of high quality care was at the forefront. We observed staff supporting each other to ensure the best possible service was provided for all patients.

**Public engagement**

- Quality was measured by survey, comments cards and the friends and family test results. 'You said, we did' boards were displayed in some patient waiting areas Comments cards and patient satisfaction surveys had taken place within outpatients and diagnostic imaging.
- Periodically a patient survey was completed under the Commissioning for Quality and Innovation payment framework (CQUIN). The last CQUIN undertaken was under the surgical outpatient speciality in February 2015. Most patients were satisfied with booking process, were seen in a timely way and had received enough information.
- The Friends and Family test had been completed recently. The results showed that 93% of patients completing the survey agreed that they would recommend the hospital to family and friends.

**Staff engagement**

- In diagnostic imaging the new management team were tackling negative comments from the staff survey by introducing a radiographer to be a 'staff representative'. This role was to support and implement positive changes within the department that staff members themselves had recommended. Staff said this was working well and welcomed the opportunity to have a voice within the department.
- The trust held the 'WOW' awards, to recognise and congratulate outstanding contributions and achievements from members of staff. A trust employee could be nominated by another member of the trust, or by a member of the public. A certificate was provided and an awards evening held to celebrate individual achievement. One member of staff in the Andover outpatient's department had received a WOW award.
- Members of staff who had been employed by the trust for certain significant period of time were also rewarded for their contribution, by being given a certificate and gift as a thank you. A member of outpatients' staff told us that they had received a long service award which had made them feel valued.

**Innovation, improvement and sustainability**

- Staff were unable to provide examples of innovation or improvement.
- The breast unit had fully integrated to provide a coordinated service across trust sites. The unit could be accessed from clinics at Andover.

# Outstanding practice and areas for improvement

## Outstanding practice

- Kingfisher ward had activity coordinators who planned and conducted different activities for patients after consulting them. There was a range of activities offered, including arts and crafts, music, dance, group lunches and movie time.
- Pregnant women were able to call Labour Line which was the first of its kind introduced in the country. This services involved midwives based at the local ambulance operations centre. Women who called 999 could discuss their birth plan, make arrangements for their birth and ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners. Labour Line midwives were able to prioritise ambulances to women in labour if they were considered an emergency. The continuity of care and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they were also awarded second place in the Midwifery Service of the Year Award.
- The specialist palliative care team provided a comprehensive training programme for all staff involved in delivering end of life care.
- The cardiac palliative care clinic identified and supported those patients with a non-cancer diagnosis who had been recognised as requiring end of life care.
- The Countess of Brecknock Hospice contacted bereaved relatives following the death of a relative and, sent a card on the anniversary of the patient's death.
- The hospice at home service was proactive in supporting patients in their own home.
- The use of the butterfly initiative promoted dignity and respect for the deceased and their relatives.
- There was strong clinical leadership for the end of life service with an obvious commitment to improving and sustaining care delivery for those patients at the end of their lives. All staff throughout the Countess of Brecknock Hospice were dedicated to providing compassionate end of life care.

## Areas for improvement

### Action the hospital MUST take to improve

**Action the hospital MUST take to improve**

The hospital must ensure

- MIU staff have access to up to date approved Patient Group Directions (PGDs).
- MIU staff receive update mandatory training in basic life support and infection control.
- Safeguarding checks are consistently completed and recorded.
- Resuscitation equipment in appropriately checked and equipment is sealed and tagged.
- There is a clear hospital protocol for responding to a collapsed patient in an emergency.
- There is appropriate security on site for the protection of staff and patients in the MIU.
- Leadership concerns in the MIU are addressed and there is effective leadership from the nurse clinical lead and lead consultant to monitor and maintain clinical standards.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- There is an effective system to identify, assess, monitor and improve the quality and safety of the MIU, the day care unit and outpatient services.

# Outstanding practice and areas for improvement

## Action the hospital SHOULD take to improve

**Action the hospital SHOULD take to improve**

The hospital should ensure:

- Staff receive appropriate training and there is a formal process in place for staff to follow to meet requirements of the Duty of Candour.
- The availability of medical notes for outpatient clinics continues to improve and this should be audited.
- There is a formal method to identify patient's whose condition might deteriorate in the outpatient clinic.
- All staff receive training on the Mental Capacity Act and Deprivation of Liberty Safeguards and mental capacity assessments are always documented or regularly reviewed in patient care records.
- Patients receive better access to therapy services to continue rehabilitation over weekends.
- Clean equipment is clearly identified for use and is appropriately separated from dirty equipment.
- Ensure bariatric equipment is available when required.
- Continue to recruit to support radiographers and assess the impact of vacancies on staff.
- All staff have appropriate clinical supervision.
- The Maternity Centre has better access to defibrillator equipment.
- Medicines are appropriately stored in the Maternity Centre.
- Clinical audit programmes are developed in all services.
- Information is being measured, monitored and recorded regarding outcomes for women.
- Theatre capacity is reviewed and patients are not waiting longer than 18 weeks for surgery.
- Patient have staggered admissions for day surgery.
- Patient operations are not cancelled on the day of surgery for non-clinical reasons.
- Patient's privacy and dignity is maintained on the day care unit by reviewing same sex arrangements.
- There is service continuity with local funeral directors to collect deceased bodies from the Countess of Brecknock Hospice, to reduce the risk of any services being withdrawn.
- The process for 'fast-track' discharge for end of life care is reviewed so that the standard is met.
- Improve staff engagement in the MIU, day surgery unit and outpatients.
- There are formal methods to feedback complaints to staff.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment<br><br>Regulation 12 (1) (2) (b), (c), (g), (f),<br><br>How the regulation was not being met:<br><br>The trust must ensure:<br><br>· MIU staff have access to up to date approved Patient Group Directions (PGDs)<br><br>· MIU staff receive update mandatory training in basic life support and infection control<br><br>· Safeguarding checks are consistently completed and recorded<br><br>· Resuscitation equipment in appropriately checked and equipment is sealed and tagged |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance |

This section is primarily information for the provider

# Requirement notices

Regulation 17 (1), (2)(a), (b).

How the regulation was not being met:

The trust must ensure:

· There is a clear hospital protocol for responding to a collapsed patient in an emergency.

· There is appropriate security on site for the protection of staff and patients in the MIU.

· Leadership concerns in the MIU are addressed and there is effective leadership from the nurse clinical lead and lead consultant to monitor and maintain clinical standards.

· There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.

· There is an effective system to identify, assess, monitor and improve the quality and safety of the MIU, the day care unit and outpatient services.