

Portsmouth Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Good



Are services at this trust caring?

Outstanding



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

Services provided at Queen Alexandra Hospital include accident and emergency, medical care, surgery, critical care, maternity and gynaecological services, children and young people's services, end of life care, and outpatient and diagnostic services. These eight core services are

always inspected by the Care Quality Commission (CQC) as part of its new approach to the comprehensive inspection of hospitals. The services provided in community hospitals are integrated into the trust clinical and management structures; we have incorporated these within the core service areas.

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

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

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

Our key findings were as follows:

Is the trust well-led?

- The trust had a three year strategy that aimed to deliver high quality patient care, working in partnership and supporting innovation in healthcare. There was a focus on emergency care with plans to transform services to reduce admissions to hospital and deliver care closer to home. However, many of these priorities were underdeveloped and the trust was dealing with the immediacy of capacity issues. Clinical services did not have joined up strategies and did not work effectively to support the flow of patients through hospital.
- The leadership team was in the process of change and development. There was the commitment to improve and deliver excellent services, but there were gaps in operational performance and delivery, particularly around the unscheduled care pathway. The trust had worked with the wider health economy but did not have clear plans to deliver service improvements and

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had not effectively delivered consistent improvement. There was a wide variation in the quality and safety of services across the trust, although many services were good or outstanding some areas of performance failures were not appropriately recognised. There had not been a recent formal assessment of the board's performance.

- The trust had all the elements of an effective governance framework but these were not being used effectively. There was a comprehensive integrated performance report to benchmark quality, operational, financial and workforce information and each clinical service centre had a quality dashboard. However, some risks were not identified and the action taken on known risks did not always mitigate these and were not always timely. Some risks had been on risk registers for several years without a clear resolution of the mitigating actions or a monitoring statement for risks that cannot be fully mitigated.
- We served two warning notices for the trust failure to respond to patient safety issues, and the failure to effectively assess and manage the risks to patients in the emergency department.
- Staff were positive about working for the trust and the quality of care they provided. The trust was similar to other trusts for staff engagement, but its staff survey had demonstrated year on year improvement. The trust 'Listening into Action' programme had demonstrated changes and improvements to services based on staff innovations. The staff had a strong sense of identify that was focused on care.
- There was a focus on improving patient experience and public engagement was developing. Safety Information was displayed in ward and clinic areas for patients and the public to see.
- The trust had a culture of innovation and research and staff were encouraged to participate. The trust had won a national award for clinical impact research. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients.
- Cost improvement programmes were identified but savings were not being delivered as planned and the trust was having to take further action to reduce the risks of financial deficit.

Are services safe?

- Patients who arrived by ambulance at the emergency department (ED) were at risk of unsafe care and treatment. We served two warning notices to the trust requiring immediate improvement to be made to the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED.
- Patients were sometimes assessed according to the time that they arrived in the ED and not according to clinical need. Some patients with serious conditions waited over an hour to be clinically assessed, which meant that their condition was at risk of deteriorating. Many patients waited in corridors and in temporary bay areas. Patient in these areas and in the majors queue area were not adequately observed or monitored.
- The trust had introduced an initial clinical assessment by a healthcare assistant to mitigate risks, but this was not in line with national clinical guidelines.
- The environment in the ED did not enhance patient safety. The ED had been extended and its majors treatment area and children's treatment area were now a considerable distance from the resuscitation room. Staff had to negotiate crowded public areas in order to gain access to the resuscitation room. Patients were in areas, some temporary, where there was no access to essential equipment or call bells, and there was no safe area to support patients with a mental health condition.
- Nurse staffing levels were regularly reviewed using an appropriate and recognised management tool. There were high vacancy levels across the hospital, notably in the ED, the medical elderly care wards and the surgical assessment unit, where staffing levels were not always met and there were insufficient staff for the number of patients and the complexity of their care and treatment needs. Staffing levels were reviewed on a shift-by-shift basis and according to individual nursing requirements. Staff were transferred across units on a shift basis to try to reduce risk, but this affected the availability of expertise and continuity of care in other areas. There was high use of internal bank and agency staff, particularly on night shifts. Agency staff received an induction and safety briefing on wards before beginning their shift.
- Midwifery staff ratio was an average of 1:29 which was in line with the England average. The maternity dashboard clinical scorecard showed that the ratio

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had varied from 1:27 to 1:33 over the past 10 months. This reflected the actual number of midwives to birth and did not include maternity support workers. The recommendations of the Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) that there should be an average midwife to birth ratio of 1:28. Midwives, however, were working flexibly and one to one care was being provided for women in labour and with additional staff or strategies were provided to ensure the safety of antenatal and postoperative care.

- The trust had higher numbers than the England average of consultant medical staff in post, although it was not meeting national recommendations for consultant presence in maternity and for consultant staffing in end of life care. The trust had fewer middle-grade doctors and junior doctors compared with the England average and their workload was high in some specialties. For example, surgery and consultants in the ED were being stretched in an unsustainable way to cover posts and ensure safe services.
- Medical patients who were in the ED overnight and those on non-medical wards (outliers) were not always reviewed by specialist doctors in a timely way.
- Most services had a culture of openness and transparency. Staff understood the principles of duty of candour, and information, guidance and training were available to support staff to understand and implement the requirement of being open when things go wrong.
- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, venous thromboembolism (blood clots), catheter-related urinary tract infections and falls. The information was monitored throughout the hospital and the results were displayed for the public in clinical areas. The prevalence of catheter-related urinary tract infections was consistently low but the incidence of pressure ulcers and falls had not reduced but was increasing. Some pressure ulcer incidents were deemed unavoidable. However, the trust had not met its own targets for reduction in pressure ulcers and falls. There was evidence of actions taken in response but this varied; for example, the falls care bundle was used on medical wards but this was not used consistently on surgical wards.
- Staff were reporting incidents and lessons were learnt and practice was changed as a result. On one surgical ward, however, staff were concerned that disciplinary action could be instigated unfairly for pressure ulcer incidents. The trust had said that staff may face disciplinary action if they failed to care for patients appropriately, but not if it was beyond their control. Recent hospital data, however, indicated a decrease in the reporting of pressure ulcers on this ward.
- The wards were visibly clean, and infection control practices were followed. The trust infection rates for MRSA and Clostridium difficile were within an expected range and the trust had not had a norovirus outbreak for five years. However, infection control arrangements in the surgical high care unit did not meet professional guidelines.
- Items of necessary equipment such as pressure-relieving mattresses, blood pressure monitors and medication pumps were not always readily available for patients when required. This meant that patient care and treatment could be delayed or adversely affected. The cardiac arrest call bell system in the E level theatres did not identify the location in which an emergency took place.
- Medicines were stored safely. However, the staff on a unit designated as an escalation ward told us they sometimes ran out of essential medications and had to borrow them from another ward. As a result there were delays in the timely administration.
- Patients whose condition might deteriorate were being identified through the use of the early warning score. The trust had an electronic monitoring system for patients and this was used effectively, for example for the critical care outreach team to prioritise patients. However, early warning scores were not being used as part of bed management allocations.
- Staff were not always aware of standardised protocols or agreed indicators for pre-assessment to support them in making decisions about the appropriateness of patients for day case surgery.
- Safeguarding processes to protect vulnerable adults, and children and young people were embedded across the hospital. There was a recent safeguarding policy and procedure, staff had attended appropriate training, and there was a culture of appropriate reporting.

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- Staff were undertaking mandatory training and progress towards trust targets was good for many staff disciplines with the exception of medical staff where attendance rates were low.
- The completion of patient records varied in some areas it was very good and in some places information could be missing, and it was not clear if this was part of the electronic or paper record. New end of life care plans were being piloted in response to the national withdrawal of the Liverpool Care Pathway. However, where these care plans were not used, the documentation, of care was not appropriate to properly assess and make decisions about patient care and treatment. Do not attempt cardiopulmonary resuscitation forms were not always appropriately completed.

Are services effective?

- Services provided care and treatment in line with national best practice guidelines, and outcomes for patients were often better than average or improving. However, operating procedures in theatres needed updating and end of life care guidance needed to be further developed across the trust. The trust needed to improve the management of stroke patients and it was not meeting the target for 90% of stroke patients to be cared for in a stroke unit.
- There was good participation in national and local audit programmes, although the trust did not fully participate in the National Care of the Dying Audit – Hospitals 2013/14.
- Patient outcomes, as measured by national audits, were either better than or similar to the England average; where they were below the average they were improving. Each clinical service centre had a quality dashboard to monitor patient safety outcomes although these needed further development to focus on clinical outcomes.
- The trust's mortality rates were within the expected range.
- Patients received good pain relief, in particular after surgery, in critical care and in end of life care. There were some delays, however, for patients who had arrived by ambulance in the ED.
- Patients, particularly older patients, were supported to ensure their hydration and nutrition needs were met. Although there were areas of concern identified on ward E3 for all patients and in end of life care on the acute medical unit.
- Staff were supported to access training and there was evidence of staff appraisal, although clinical supervision for nursing staff was under developed.
- Staff worked in multidisciplinary teams to centre care around patients. Physiotherapists on medical wards told us that although they did see medical patients, they could not always provide sufficient therapy sessions for their individual requirements.
- Discharge summaries giving GPs information on patient care were delayed. The trust was not meeting Department of Health standards for letters to be sent within 48 hours and there could be delays of up to two weeks. Renal outpatient letters were taking 35 days to be typed and sent to the patients' GP because the renal department had a separate IT system from the rest of the trust. This had caused significant delay in GPs receiving updated information regarding their patients' treatment.
- Seven-day consultant-led services were developed in all areas, with the exception of outpatient services. Support services such as imaging, pharmacy, physiotherapy and occupational therapy were also available seven days a week.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission.
- Critical care services demonstrated outstanding innovations in delivery of effective care, ensuring there were robust systems to deliver and monitor care to high standards by highly skilled staff.

Are services caring?

- The trust had a culture of compassionate care. Staff were caring and compassionate, and treated patients with dignity and respect. Many patients and relatives

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told us that although staff were very busy, they were supported with compassion, patience, dignity and respect, with time being given to the delivery of personalised care.

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

Are services responsive?

- The trust was not meeting national targets for the timely handover of patients from ambulances. The trust had not met the emergency access target for 95% of patients to be admitted, discharged or transferred from A&E within four hours since November 2013. There was no hospital-wide escalation response to overcrowding in the ED to improve flow in the hospital.
- Specialty teams were often delayed in seeing patients who had been in the ED overnight.
- Bed occupancy across the hospital was 92% (January 2014 to March 2015). This was consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Patients were not always admitted to wards according to their clinical needs and were being placed where beds became available. This meant that the necessary level of specialist expertise and experience may not always have been available to them.
- Patients could be moved several times during their admission. This happened at night and for non-clinical reasons. The trust identified that older patients, patients with high dependency and acuity needs and end of life care patients should not be moved. However, older patients, including patients who were confused, or living with dementia and who may have had complex conditions, were being moved.
- Patient moves were tracked but the information was not used effectively at ward level. Some medical staff told us they did not always know where to find them and this could lead to a delay in treatment. Patients' relatives also told us that they had difficulty finding patients.
- The critical care unit experienced discharge delays out of hours and delays to admission because of pressure on beds in the hospital. The unit had taken action to mitigate risks and this included comprehensive discharge summaries and a retrieval team who care for patients on the ward while they waited for admission.
- The national referral to treatment time target for 90% of patients to have surgery within 18 weeks was not met overall, although this was a planned fail in agreement with commissioners to address patients on the waiting list. Targets were not achieved in general surgery, trauma and orthopaedics, urology and ENT. In relation to urology, the trust attributed delays to limited staffing capacity, which had led to the cancellation of over 200 elective surgeries and a reduction in the number of elective patients admitted.
- Capacity issues within the hospital resulted in elective procedures being cancelled. Some patients told us their operations had been cancelled several times; although the majority did go on to have their surgery within 28 days.
- The trust was meeting the cancer waiting time target for 93% of patients to have referral from a GP to see a specialist within two weeks. The trust was also meeting the target for 96% of patients to have diagnosis to definitive treatment within one month (31 days). The trust had also met the target for 85% of

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patients to be waiting less than two months (62 days) from referral to start of treatment from April 2014 to December 2014. However, the target had not been met in January 2015 to March 2015.

- The trust was meeting referral-to-treatment time targets for most outpatient specialities but there were long waiting times for patients attending colorectal clinics, back pain clinics and the gastroenterology clinic. There was evidence of action being taken to address the long waits.
- Patient had timely follow up outpatient appointments although there were patients waiting beyond their due date in colorectal surgery, orthopaedic and gastro specialities. Ophthalmology had a high number of patients with significant delays to follow-up and who were on an outpatients waiting list. This had been on the service risk register since 2009, but as a result of a serious incident requiring investigation that occurred as a result of this backlog, it was escalated to the trust risk register In April 2013. The waiting list had been reduced but the number of patients waiting was still significant
- The trust was now meeting the diagnostic waiting time target after extending the service times.
- Discharge plans were expected to commence on admission but this varied across wards, as did planning around simple and complex discharges. There were some delays in discharging patients and patients told us they had to wait a considerable time (hours) for their medications to take home. A discharge lounge was available and was used appropriately. Patients were able to have food and drink while waiting for discharge.
- The trust had delayed transfers of care and national data showed the main causes of delayed transfers of care at this trust (which could prevent a patient from being discharged) included waiting for nursing home places, waiting for social care arrangements, and patient/family choice. The trust was working with its partners to alleviate this problem and data published by NHS England (December 2014 to January 2015) demonstrated that the trust had a comparatively smaller number of delayed discharges compared with other similar trusts.
- The integrated model which the trust maternity service runs (Nurture programme) allowed flexible use of staff to maintain 1:1 care in labour. This had kept women's denied choice of place of birth to a minimum.
- There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than the national average.
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. However, this was not the case for ambulance patients waiting in corridors in the emergency department and also for patients in the dialysis unit on the Isle of Wight. Patients attending for outpatient appointments had to walk through the dialysis unit where patients were receiving treatment in their beds to attend their consultations. In ophthalmology department at Queen Alexandra Hospital, patients receiving treatment (pupil dilation) were being treated in a room that was glass walled, enabling any person walking by to observe a patient being treated.
- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients with a learning disability. However, care for patients living with dementia varied. Training, assessment, the use of the dementia care bundle and making reasonable adjustments to reduce stress and anxiety, we being used but not consistently. In some areas the care needs of people living with dementia were not always met. Some areas demonstrated excellent examples of the care such the 'memory lane' service on the elderly care wards. This was held once a week and included engaging patients in remembering their past times by means of music, games, reading material and communication.
- An interpreting service was available for people whose first language was not English and the service was used. All information for patients was only available in English. In radiology, easy-to-read leaflets were available for patients with a learning disability, where language style had been adjusted and pictures used to explain procedures. We did not see any other information in an easy-to-read format.
- Information from complaints was reviewed and acted on; although some patients told us they were not always given information about how to make a complaint.

Are services well-led?

- Many staff were committed to the values of the trust: 'best hospital, best people, best care'.

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- Most services did not have a formal written strategy, although aspects of future plans could be verbalised by staff. Staff in the ED were not aware or confident that there were clear plans and strategies to address significant concerns in a timely way.
 - Departmental strategies and vision were generally well understood, except in medicine where no discernible long-term strategy could be described by staff.
 - Clinical governance arrangements were well developed to assess and manage the quality of service provision. However, better management of risks was needed. Not all risks were appropriately identified, escalated and mitigated across service areas. The pressures in the ED were long-term and significant risks to patients had not been appropriately managed.
 - Many staff told us overall they had good support from the local clinical leaders, for example ward managers and consultant staff. However, there were concerns, including: the support from managers at senior levels, the capacity of managers in the ED, of some ward managers and the fragmentation of management in end of life care.
 - Many staff commented on the visible and approachable presence of the chief executive officer.
 - Staff were positive and proud to work for the trust; many staff had worked in the trust for their entire career. There was an open and honest culture and a strong sense of teamwork across most areas. However, there were a few areas of concern and these were identified as the lack of hospital support and clinical engagement for the pressures in ED, the lack of integrated working across clinical service centres, the concern by staff on one ward of being unfairly disciplined for pressure ulcer incidents in surgery and the dysfunction team working in the colorectal team.
 - There were innovative approaches to patient and public engagement across services, which included survey, focus groups, consultation, committee representation and the use of social media.
 - Staff engagement was good, and the latest staff survey showed significant improvement in key areas. The trust was in the top 20% of trusts for staff engagement. The Listening in Action programme was cited as a particular example of involving staff in improving the quality of their services.
 - There was a strong and visible commitment to research and development.
 - Innovative ideas and approaches to care were encouraged and supported, and the trust was the recipient of many awards, both national and international, for the excellence of some of its services.
 - The leadership in the critical care unit was outstanding.
- We saw many areas of outstanding practice including:
- A 'Coffee and conversation' group was held for patients in the stroke wards. This gave patients an opportunity to share their experiences, provide peer support and education. Patients were also given information about support available in the community.
 - There were good arrangements for meeting the needs of patients with a learning disability, particularly in theatres. The staff showed good awareness of the specialist support that patients with complex needs sometimes require. Staff used a specialist pain management tool for assessing pain levels in patients who could not verbally communicate their experiences of pain.
 - The trust had developed bespoke safeguarding training modules to meet the specific needs of staff and their working environments. For example, there was safeguarding training specific to the issues identified for staff working in theatres and specific types of wards.
 - The practice of daily safety briefings on the intensive care unit (ICU) ensured the whole multidisciplinary team was aware of potential risks to patients and the running of the unit.
 - In the ICU there were innovative approaches to the development and use of IT systems and social media. Secure Facebook and Twitter accounts enabled staff to be updated about events affecting the running of the service. This included information about risks, potential risks and incidents. Electronic 'Watch out' screens in the unit displayed information about incidents and the unit's risk register. The education team advertised information about training opportunities on the education Twitter account.
 - In the ICU, innovative electronic recording systems supported the effective assessment and monitoring of patients.

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- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time and the outreach team to monitor patients on all wards and prioritise which patients they needed to attend to. This early warning system was developed in response to delayed care in deteriorating patients. Its adoption has saved over 400 deaths, and overall has reduced our mortality levels by 15%.
- Innovative and practical planning of emergency trolleys meant that all equipment needed to manage a patient's airway, including equipment to manage difficult airways and surgical equipment, was stored in a logical order and was immediately accessible.
- In most critical care services, beds are positioned to face into the ward. On some units beds were positioned so that conscious patients could look out of the window. Queen Alexandra Hospital's critical care unit had learnt that some patients were frightened when they could not see the ward and wanted to be able to see into the unit for reassurance. In response, the unit had equipment that could position beds at an angle so patients could see out of window as well as into the unit.
- In response to difficulties in recruiting middle-grade (registrar) doctors, the ICU in partnership with the University of Portsmouth was developing a two-year course in Advanced Critical Care Practice (ACCP). The planned outcome from this course was that Advanced Critical Care Practitioners would be employed in the unit to fulfil some of the medical tasks and release medical staff to do more complicated work. This was the first initiative of this kind in the UK.
- To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the ICU had an innovative practice of retrieving the patient from elsewhere in the hospital. Patients admitted into the emergency department (ED) requiring critical care were treated by the critical care team in the ED, before admission to the unit. The same practice was followed for patients requiring admission to the unit from the general wards.
- The innovative use of grab packs meant staff had instant guidance about what to do in the event of utility failure, emergency telephone breakdown and major incidents.
- The critical care unit had developed their own innovative website that included educational information and guidance documents. There was guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.
- A perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation.
- There was a telephone scheme for women who had experienced complex or traumatic deliveries to talk about, and have a debrief conversation, with a midwife following their discharge. The outcomes from the conversations were used as part of the governance processes and this had demonstrated a reduction in the number of complaints.
- A mobile telephone application (app) had been developed by the trust and the Chair of the Midwife Liaison Committee together with women who used the services. The app provided information on choices of place of birth and was being developed to include additional information. The app won an award from NHS England in the excellence in people category and the service had also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- The multidisciplinary team in the children's and young people's services had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families. We found all staff, at all levels, were involved in working towards this goal and this was having a positive impact on improving the safety and quality of services for children, young people and their families.
- There was a new initiative called a 'talent panel', which was a mechanism to discover and develop staff, both for individual career development and the future

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sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified.

- The trust had introduced a volunteer programme for people who wanted to work as a chaplain's assistant. Volunteers were trained on how to support patients through visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust received a national award for clinical research impact. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients. The trust identified the development of the early warning system, mobile application for pregnant mothers (cited above), and developing methodologies to reduced respiratory exacerbations and admissions and detect upper and lower gastrointestinal cancer more effectively.

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

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

- Patients are appropriately assessed and monitored in the ED to ensure they receive appropriate care and treatment.
- Ambulance patients are received and triaged in the ED by a qualified healthcare professional.
- There are effective system to identify, assess and manage the risks in the ED.
- There is an adequate supply of basic equipment and timely provision of pressure-relieving mattresses.
- The cardiac arrest call bell system in E level theatres is able to identify the location of the emergency.
- Medication is prescribed appropriately in surgery and is administered as prescribed in gynaecology
- The emergency resuscitation trolley on the gynaecology ward is appropriately checked.
- Appropriate standards of care are maintained on ward E3 and the acute medical unit.
- There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.
- Patients' bed moves are appropriately monitored and there is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night, several times and for non-clinical reasons.
- Patients are allocated to specialist wards, when clinical need requires this, and medical outliers are regularly reviewed by medical consultants.
- Nurse staffing levels comply with safer staffing levels guidance.
- There are adequate numbers of medical staff on shifts at all times.
- All wards have the required skill mix to ensure patients are adequately supported by competent staff.
- The falls action plans are followed in a consistent way across the medical services.
- There is compliance with the WHO Surgical Safety Checklist.
- Staff awareness of standard protocols or agreed indicators for pre-assessment improves to support them in making decisions about the appropriateness of patients for day case surgery.
- Staff on all wards are able to raise concerns above ward level, particularly when this impacts on patient care, and there is a response to these concerns.
- Discharge summaries are sent out in a timely manner and include all relevant information in line with Department of Health (2009) guidelines.
- Staff observe recognised professional hand hygiene standards at all times.
- The surgical high care unit is risk-assessed for infection control risks.
- Medical and dental staff complete mandatory and statutory training.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Nursing handovers provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.
- Nursing staff are appropriately trained in the safe use of syringe drivers.
- All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded.
- Patient confidentiality is protected so that patients and visitors cannot overhear confidential discussions about patients' care and treatment.
- Records are kept relating to the assessment and monitoring of deteriorating patients in recovery.

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- Patient records and drug charts are complete and contain all required information relating to a patient's care and treatment.
- Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.
- Patient records are stored so that confidentiality is maintained.
- The trust fully participates in all national audits for which it is eligible on end of life care.
- Action is taken to improve the leadership where there are services and ward areas of concern.

At a trust level:

- The trust clinical strategy is supported by clear improvement plans and these are monitored and evaluated appropriately.

- Governance arrangements are managed effectively so that there is appropriate assurance around risk and performance.
- The trust board has a development programme and there should be appropriate and timely assessment of its performance.
- There is continued investment in PALS.
- Complaints are appropriately monitored and responded to in a timely manner.

In addition, the trust has a number of actions that it should take and these are identified in the location report for Queen Alexandra Hospital.

Professor Sir Mike Richards, Chief Inspector of Hospitals

Summary of findings

Background to Portsmouth Hospitals NHS Trust

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

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

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

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

Our inspection team

Our inspection team was led by:

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

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

The team of 56 included CQC managers, inspectors and analysts, and a variety of specialists including: consultant in emergency medicine; consultant gynaecologist and obstetrician; consultant surgeon; consultant anaesthetist;

consultant physicians; consultant geriatricians; consultant radiologist; consultant oncologist; consultant paediatrician; junior doctor; emergency department matron; midwife; gynaecology nurse; surgical nurses; theatre nurse; medical nurses; paediatric nurses, neonatal nurse specialist, optometrist; palliative care specialist nurse; critical care nurses; outpatient manager, board-level clinicians; governance lead; safeguarding leads; a student nurse; and experts by experience.

Summary of 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 from 10 to 13 February 2015. We completed the inspection through unannounced and out-of-hours inspections to services on 25 and 26 February and 2 March 2015.

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

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Portsmouth on 10 February 2015 when people shared their views and experiences of the Portsmouth Hospitals NHS Trust.

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

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

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

What people who use the trust's services say

- We held a public listening event, on 9 February 2015. The event was attended by 110 people. Overall people were positive about the trust but identified some areas for improvement.

There were positive comments on the following:

- The hospital was friendly and had a strong sense of identity
- Consultants staff were caring, approachable and took time to listen
- Staff were caring in the Emergency Department
- Good cancer care and good care from the renal teams
- Good care in vascular and orthopaedic surgery and nursing staff on the surgical admissions unit were good
- Excellent care in the critical care unit and high dependency unit.
- Good experience of maternity services overall

- Outpatient services were good - Hearing Aid service, Fracture Liaison Service Rheumatology service. Telephone reminders for outpatient appointments were helpful.

There were negative comments on the following:

- Nurse staffing at night - nurses were understaffed and dismissive to patients
- Nurse handover was incorrect and nursing staff were defensive with information was corrected
- Too few nursing staff for the hospital
- Medical outliers received inappropriate care
- Multiple moves of elderly patients between wards
- IT systems not fit for purpose and nurses had too much paperwork
- Infection control practices needed to improve
- Electronic consent meant patients did not receive a copy
- Poor liaison with social services for discharge

Summary of findings

- The Patient Advice and Liaison Service (PALS) was not well advertised
- Long waiting times in the ED on a trolley with no privacy
- Many people with alcohol and drug problems in the ED
- Unsatisfactory discharge from the medical assessment unit
- Physiotherapists mobilised patients with fractured hips too early
- Poor dementia care and families not informed;
- Patients on the Liverpool Care Pathway and families not informed.
- Long waiting time in outpatients for hearing aids and for X-ray
- Detail in outpatient letters insufficient and too complex.
- Missing medical records on multiple occasions in outpatients.
- The results of the NHS Friends and Family Test (FFT) January - July 2014 showed that the trust scored above the England average overall for inpatient wards. The A&E scores showed that the trust was above the England average. Recent scores up to December 2014 showed that trust had a net score that was in the top 20% of trusts.
- The CQC adult inpatient survey (2013): The trust had performed similar to other trusts in the six areas of question on the hospital and ward, nurses, doctors, care and treatment, operations and procedures and leaving hospital.
- The CQC A&E survey (2014): The trust performed similar to other trusts for all questions. The questions covered
- The Cancer Patient Experience Survey (CPES) by the Department of Health 2013/14 is designed to monitor national progress on cancer care. Of 34 questions, the trust performed similar to other trusts overall. The trust was worse than other trusts (in the bottom 20% of trusts) for two questions: patient's GP given enough information about their condition and treatment and patients never thought they were given conflicting information. The trust was better than other trust (in the top 20% of trust) for two questions: Staff told patients who to contact following discharge and patients saw their GP once or twice before being told they were going into hospital.
- The CQC Survey of Women's Experiences of Birth 2014 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth.
- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. In 2014, the trust scored higher than the national average for cleanliness (99%, compared to 98% nationally), privacy, dignity and well-being (92%, compared to 87%), and facilities (96%, compared to 92%). However food and hydration was below the national average (97%, compared to 90%).

Facts and data about this trust

Portsmouth Hospitals NHS Trust: Key facts and figures

PHT has five registered locations: The Queen Alexandra Hospital, Gosport War Memorial Hospital, St Mary's Community Campus, Fareham Community Hospital, Petersfield Community Hospital, St and eight Renal Dialysis Units across Hampshire and the Isle of Wight.

The majority of the Trust's acute services are now provided at Queen Alexandra Hospital following the completion of recent redevelopment.

1. Context:

- Queen Alexandra Hospital has around 1,255 beds.
- Gosport War Memorial Hospital - Ark Royal Ward (16 beds) and Blake Maternity Unit (6 beds)
- Petersfield Community Hospital (Cedar Ward) (22 beds).
- The local population is around 550,000.
- The number of staff is around 7,000.
- The board has 0% Black and ethnic minority members representation of executive directors and 0% Black and ethnic minority members representation of non-executive directors; it has 33.3% female representation of executive directors and 20% female representation of non-executive directors.

Summary of findings

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

2. Activity:

- Inpatient admissions: 96,146 (2013/14).
- Outpatient attendances: 463,515 (11/2013 to 10/2014).
- A&E attendances: 137,864 (11/2013 to 10/2014).
- Births: 5,966 (July 2013 to June 2014) 98.5% single births and 1.5% multiple births.
- Deaths: 805 (April 2013 to March 2014).

3. Bed occupancy:

- General and acute: 92.2% (April 2014 to June 2014). This was consistently above both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Maternity was at 71% bed occupancy (April 2014 to June 2014) and consistently higher than the England average of 57.9%.
- Adult critical care was at 82.4% bed occupancy – below the England average of 87.6% in January 2015.
- Level three neonatal intensive care unit.

4. Intelligent Monitoring:

Priority banding for inspection*

Oct 13 - 4 (4.3%)

Mar 14 - 6 (0.5%)

Jul 14 - 6 (2.1%)

Dec 14 - 6 (3.2%)

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

Individual risks/elevated risks:

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

5. Safe:

- 'Never events' in past year: 3 (2013/14).
- Serious incidents: 116 (2013/14) – 63% were pressure ulcers.
- National Reporting and Learning System April 2013 to May 2014; no evidence of risk.

Acute

Death - 7 (0.1%)

Severe harm - 101 (1.3%)

Moderate harm - 138 (1.8%)

Low harm - 2,405 (30.5%)

No harm - 5,212 (66.3%)

Total 7,863

Infection control (March 2013 to September 2014)

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

Waiting times – Safe Domain

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

6. Effective:

(December 2014)

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

7. Caring:

- CQC Inpatient Survey (10 areas): similar to other trusts.

Summary of findings

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

8. Responsive:

- A&E four-hour standard – not met; below the England average and 95% target (April 2013 to December 2014).
- Emergency admissions waiting 4–12 hours in A&E from decision to admit to admission: above the England average.
- A&E left without being seen: above the England average (December 2013 to September 2014).
- 18-week referral-to-treatment – surgery (admitted adjusted) – similar to 90% NHS operating standard (April 2013 to June 2014).
- 18-week referral-to-treatment (non-admitted and incomplete pathways – outpatient) – above 95% NHS operating standard (April 2013 to June 2014).
- Cancelled operations and not treated within 28 days – above the England average in June 2014.
- Cancer waiting times: Better than or similar to England average for urgent two weeks (seen by specialist), 31 days (diagnosis to treatment) and 62 days (urgent referral to treatment).

- Diagnostic waiting times – Although flagged as an Elevated Risk by Intelligent Monitoring, waiting times had dropped below the England average by October 2014.

9. Well-led:


- NHS Staff survey 2013 (30 questions): Better than expected (in top 20% of trusts) for two questions; worse than expected for seven questions; similar to expected for 21 questions.
- Use of bank and agency staff – below the England average.
- Sickness rate – below the England average.
- General Medical Council National Training Scheme Survey (2013): The trust was within expectations for all areas of the National Training Scheme Survey.

10. CQC Inspection History:

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

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>By safe, we mean that people are protected from abuse and avoidable harm.</p> <p>Overall we rated the safety of the services at the trust as 'requires improvement'. For specific information, please refer to the individual reports for Queen Alexandra Hospital.</p> <p>The team made eight separate judgements about the safety of services in the trust and there was a variation in judgements. One was judged as 'inadequate', three as 'requiring improvement', three as 'good' and one as 'outstanding'. This meant that the trust did not consistently protect people from avoidable harm and also that learning to share good practice was not effective.</p> <p>The trust had patient safety priorities identified for 2014/15. These covered the development of a safety culture, reducing avoidable harms such as pressure ulcers, infections and falls, general ward safety (for example, identifying the deteriorating patient, Sepsis and acute kidney injury care) and improving the care of frail elderly and reducing medication errors. In December 2014, the trust had identified overall positive progress with the plan but there were areas where progress had not developed as plan. The trust was still in the bottom 20% of trusts for reporting incidents to the National Reporting and Learning System (NRLS) on time. Avoidable harms such as pressure ulcers and falls had not reduced by 10% according to trust plans and c.difficile infections were within an expected range but were higher than local targets.</p> <p>Critical care services demonstrated outstanding and innovative safety procedures to protect patients from avoidable harm.</p> <p>Assessing responding to risks</p> <ul style="list-style-type: none">• Patients who arrived by ambulance at the emergency department (ED) were at risk of unsafe care and treatment. We served two warning notices to the trust requiring immediate improvement to be made to the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED.• Patients were sometimes assessed according to the time that they arrived in the ED and not according to clinical need. Some patients with serious conditions waited over an hour to be clinically assessed, which meant that their condition was at risk of deteriorating. Many patients waited in corridors and in	<p>Requires improvement</p> 

Summary of findings

temporary bay areas. Patient in these areas and in the majors queue area were not adequately observed or monitored. The trust had introduced an initial clinical assessment by a healthcare assistant to mitigate risks, but this was not in line with national clinical guidelines.

- Patients whose condition might deteriorate were being identified through the use of the early warning score. The trust had an electronic monitoring system for patients and this was used effectively, for example for the critical care outreach team to prioritise patients. However, early warning scores were not being used as part of bed management allocations and we found patient with higher acuity and dependency needs being moved several times.
- The trust had introduced the “Nerve Centre” to coordinate the Hospital at Night team. This had improved the escalation of patients at risk and bed management and had reduced the number of incidents. The model of the Nerve Centre, however, did not run during the day time and bed management was run by the clinical service centres. This had caused a number of delays when identifying beds.

Duty of Candour

- The trust Duty of Candour and Being Open Policy was developed in January 2014 and advised staff to be open, transparent and candid with patients when things go wrong. The policy had been updated in January 2015, to take account of the Duty of Candour regulation which came into effect in the NHS on 27 November 2014. The policy introduced procedures and guidance for the trust to meet the requirements of the Duty of Candour.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- The principles of candour were generally well embedded in the organisation. Most services had a culture of openness and transparency even if the ‘duty of candour’ was not part of the safety vocabulary of the trust. Staff understood the principles of duty of candour, and information, guidance and training were available to support staff to understand and implement the requirement of being open when things go wrong. Senior staff

Summary of findings

could describe their responsibilities around duty of candour and all staff consistently told us that the trust supported them to be open and transparent about the need to identify mistakes, accept responsibility and apologise.

Safeguarding

- Safeguarding was overseen by the trust safeguarding committee. The trust safeguarding lead was the director of nursing and each clinical service centre had an adult safeguarding operational lead. There was a safeguarding children's team and a safeguarding children's group as a subcommittee of the trust safeguarding committee. The trust committee and children's group were monitoring the implementation of trust policies for the safeguarding of adults and children, and staff training.
- The trust was working with partners to ensure an area wide approach to safeguarding issues, particularly as the majority (75%) were related to issues about community care services, which were recognised on admission to the hospital or disclosed to staff during the patients stay. The majority of internal safeguarding alerts were for pressure ulcers and 11% were related to allegations of abuse, neglect or omissions of care. Actions as a result of safeguarding incidents were implemented and monitored. The trust annual report included reference to the implementation of new guidance and policies, for example, prevent strategies (prevention of terrorism).
- Safeguarding training for adults and children was well attending and trust targets (85% attendance) were met. Staff were aware of the relevant policies for safeguarding vulnerable adults and children and knew how to access them. Staff could describe situations in which they would raise a safeguarding concern and could describe the action they would take. There was an appropriate reporting culture.

Incidents

- Staff told us how they were encouraged to report incidents, near misses and errors and that they received feedback and learning was shared within clinical teams and service centres. There was less evidence of learning being shared across the trust.
- The trust had reported 7,863 incidents to the NRLS from April 2013 to May 2014. This was lower than expected rate of NRLS incidents. The majority (97%) of these incidents were low risk or no harm incidents. Moderate incident accounted for 2% of all incidents and serious incidents (severe harm or death) 1%.

Summary of findings

- The majority of serious incidents had been for pressure ulcers (grade 3 and 4) and venous thromboembolism. The trust had reported three Never Events in 2014, two for wrong site surgery and one drug error. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. These incidents had been investigated through root cause analysis and the learning implemented.
- We reviewed three SIRIs and found these to be well structured, with appropriate conclusions and recommendations with specific responsibilities and timescale for actions identified. There were prompts to share wider learning across the trust, but these were not always used effectively.

Staffing

- Nurse staffing levels were regularly reviewed using an appropriate and recognised management tool. There were high vacancy levels across the hospital, notably in the ED, the medical elderly care wards and the surgical assessment unit, where safe staffing levels were not always met. There were insufficient staff for the number of patients and the complexity of their care and treatment needs. Staffing levels were reviewed on a shift-by-shift basis and according to individual nursing requirements. Staff were transferred across units on a shift basis to try to reduce risk, but this affected the availability of expertise and continuity of care in other areas. There was high use of internal bank and agency staff, particularly on night shifts. Agency staff received an induction and safety briefing on wards before beginning their shift.
- The trust had higher numbers than the England average of consultant medical staff in post, although it was not meeting national recommendations for consultant presence in maternity and for consultant staffing in end of life care. The trust had fewer middle-grade doctors and junior doctors compared with the England average and their workload was high in some specialties, for example, in surgery and the ED. Consultants in the ED were being stretched in an unsustainable way to cover vacant middle grade posts and ensure safe services.
- Midwifery staff ratio was an average of 1:29 which was in line with the England average. The maternity dashboard clinical scorecard showed that the ratio had varied from 1:27 to 1:33 over the past 10 months. This reflected the actual number of midwives to birth and did not include maternity support workers. The recommendations of the Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth:

Summary of findings

Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) that there should be an average midwife to birth ratio of 1:28. Midwives, however, were working flexibly and one to one care was being provided for women in labour and with additional staff or strategies were provided to ensure the safety of antenatal and postoperative care.

Are services at this trust effective?

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

Overall we rated the effectiveness of the services at the trust as 'good'. For specific information, please refer to the individual report for Queen Alexandra Hospital.

The team made eight separate judgements about the effectiveness of services. One in end of life care was judged as 'requires improvement', six were judged as 'good', and one in critical care was judged as 'outstanding'.

Although there were some variations, this meant, overall, that patients received effective care and treatment that met their needs. National evidence-based guidelines and best practice was used to guide the treatment of patient, and clinical audit was used to monitor standards of care. Patient outcomes were good and mortality rates were within the expected range.

Patients had good pain relief although there were some delays for patients who had arrived by ambulance. Patients received appropriate nutrition and hydration although there were some concerns on ward E3 and on the acute medical unit. Staff worked in multidisciplinary teams to co-ordinate care around the patient and were supported with training and encouraged to develop their skills. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal guidelines. Seven day services were developed in many areas, including for emergency care, with the exception of outpatient services.

There was some evidence of working with community teams but overall these needed to be further developed. GP discharge summaries were delayed which did not support seamless care.

Evidence-based care and treatment

- Staff used national guidelines, for example, from NICE, and relevant Royal Colleges to determine care and treatment in local pathways, care bundles and procedures. In most areas there was adherence to guidance and policies, although we

Good



Summary of findings

identified some variations, for example operating procedures in theatres needed updating and end of life care guidance needed to be further developed across the trust. The trust needed to improve the management of stroke patients and it was not meeting the target for 90% of stroke patients to be cared for in a stroke unit.

- The trust formally reviewed all NICE guidance to agree its use and to monitor implementation across services.

Patient outcomes

- The trust participated in national audits although it had not fully participated in the National Care of the Dying Audit – Hospitals 2013/14. The trust identified to us that this had been a mistake. Standards were monitored through local clinical audit programmes. Although these could vary, each clinical service centre had a clinical audit programme and annual clinical audit report and improvements to services could be demonstrated as a result.
- Patient outcomes, as measured by national audits, were either better than England average, and or similar; where they were below the average they were improving. Each clinical service centre had a quality dashboard to monitor patient safety outcomes although these needed further development to focus on outcomes of clinical effectiveness.
- The hospital could demonstrate outcomes that were significantly better than the national average in critical care, neonatal care, colorectal surgery, cardiac surgery, orthopaedic surgery, diabetes care, rheumatology, ophthalmology, for breast and gastric cancers.
- Mortality rates in the trust was within expected range. The introduction of electronic monitoring had reduced mortality.

Multidisciplinary working

- There was good multidisciplinary team working. Staff liaised effectively on the wards to coordinate patient care and some ward rounds were conducted by multi-disciplinary teams. Patients had been referred to specialists when required, for example, speech and language therapy or for dietetic advice. However, multi-disciplinary working needed to improve in places, for example physiotherapy for medical patients and in the care of stroke patients.
- Services were also being coordinated outside the trust. For examples, GPs could refer directly to the midwifery service and,

Summary of findings

there were effective networks for intensive care, integrated working for diabetes care, and the community children's team from Solent NHS Trust supported early discharge of children with complex needs

- Discharge summaries giving GPs information on patient care were delayed across the trust. There could be delays of up to two weeks, and even longer, instead of within 48 hours. This did not promote seamless care into the community.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust had a consent policy which included details about when patients lacked capacity and where to obtain more specialist information. However, we did not have evidence that this was the subject of regular audit.
- Staff followed appropriate consent procedures. We found consent forms had been completed appropriately and included details about the procedure/operation and any possible risks or side effects were completed. Staff also demonstrated an awareness of their responsibilities under the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS) to ensure patients best interest were protected. We found, where patients lacked capacity mental capacity assessments were done although this was not demonstrated on do not attempt cardiopulmonary resuscitation forms.

Are services at this trust caring?

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

Overall we rated the caring provided by staff at the trust as 'outstanding'. For specific information, please refer to the individual report for Queen Alexandra Hospital.

The team made eight separate judgements about the caring. One was judged as 'requires improvement' Four were judged as 'good' and three, in critical care, maternity and gynaecology and children and young people's services were judged as 'outstanding'.

This meant, overall that feedback from patients was continually positive. Patients, their families and carers told us about how staff were 'excellent, kind and helpful' and many ward areas could demonstrate the plaudits they had received. The trust had a culture of compassionate care. Staff were highly motivated to provide compassion care that promoted people's dignity. Many services had a strong visible person-centred approach with individual patient preferences and needs reflected in how care was delivered.

Outstanding



Summary of findings

Patients, their relatives or carers were involved in their care and in some places, active partners, with staff empowering patients to have a voice in their care. Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Compassionate care

- The trust had an initiative in place called 'back to basics', which required staff to introduce themselves by name to patients with the understanding that this was the first step of compassionate care. We observed staff introducing themselves to patients by their preferred name.
- Staff were caring and compassionate, and treated patients with dignity and respect. Many patients and relatives told us that although staff were very busy, they were supported with compassion, patience, dignity and respect, with time being given to the delivery of personalised care. Staff were responsive to patient needs and answered call bells promptly, although this varied in a few areas. Staff in the outpatient departments were approachable, reassuring and professional.
- We observed outstanding care and compassion in critical care, maternity and gynaecology and children and young people's services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care.
- Data from the NHS Friends and Family Test demonstrated that patients were satisfied with the care they received. Overall results were above the England average and the trust was in the top quarter of all trusts. Results were clearly displayed in ward areas.
- The CQC Survey of Women's Experiences of Maternity Services 2013 and also responses to the Friends and Family Tests showed the trust to be performing about the same as other trusts in maternity care.
- The cancer patient experience survey (2013/14) was similar to other trusts overall.
- Patients' experiences of care was variable, however. There were concerns, particularly for patients on the surgical ward E3 where staff were busy, and essential and timely personal care was not delivered and patient dignity and confidentiality was not always maintained. Some patients with end of life care needs on wards E3 and the acute medical unit did not always get the timely care the families thought necessary or appropriate, and care was sometimes given by relatives instead.

Summary of findings

Understanding and involvement of patients and those close to them

- Patients and their relatives told us they were involved in decisions about their care and treatment. They told us their care and treatment options had been explained to them at all times and they had sufficient opportunity to speak with consultant staff.
- In medical services, patients on the stroke unit were involved in developing their care plan, and understood what was in place for the future management of their stroke. The therapy and nursing staff on the stroke wards arranged family meetings with patients' relatives within two weeks of patients' admission. These meetings involved discussions around patients' progress, goals and their involvement in care. The relatives we spoke with commented positively about these meetings and found them a very useful source of information.
- In critical care, patients, where possible and relatives told us they felt fully informed about care and treatment and this was discussed in a manner they could understand. Staff communicated sensitively, and provided explanations about the equipment and what was happening to reduce any anxiety. Records of conversations were detailed on the electronic recording system. This meant staff always knew what explanations had been provided and reduced the risk of confusing or conflicting information being given to relatives and patients.
- In maternity services, women described the excellent care and support, particularly if they had complex needs. They were complimentary about the detailed information provided by midwives and how this had ensured they understood the care they required without being made to worry about their condition. Women were involved in handover discussions between staff to keep them involved and informed about their care.
- In children and young people 's services, staff spent time talking to parents and also to the children and young adults so that they could all understand, in way that was meaningful and reassuring to them, what was happening during their stay. Play leaders spent time with children to support them to understand their care. Children with long term conditions or who were long stay patients had diaries to record key information and they and their parents could write questions and comments, and receive a response.
- The families of patients receiving end of life care told us they were informed about the condition of their relative and had time to speak with doctors and they did not feel rushed. They

Summary of findings

told us that staff were good at communicating and had, for example, discussed death or dying in a comforting manner. Relatives told us they were encouraged to get involved in the care of patients. For example, they were encouraged to provide mouth care for end of life care patients.

Emotional support

- Staff across the trust demonstrated a good understanding of patient's and relatives emotional needs. Emotional care was also provided by the chaplaincy department and patients and relatives told us much they valued this service. A multi-faith chapel was available for people of all faiths to support their spiritual needs.
- In the emergency department, staff gave open and honest answers to questions and provided as much reassurance as possible. Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nurses preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.
- The intensive care unit offered follow-up clinics where patients were invited to return so their stay and care in the ICU could be explained to them to aid them with their emotional recovery. Feedback from these clinics had resulted in changes to care practices to reduce anxieties experienced by patients after discharge from the unit. This included asking patients about their experiences of hallucinations while they were a patient in the ICU, assessing what actions/noises in the unit could be contributing to causing the hallucinations and trying to eliminate some of those noises and actions.
- Follow up telephone calls were offered to women who may have had a difficult or complex birth and specific assessment and support for women who may have lost their babies during pregnancy. There was also follow up telephone calls for women who had had gynaecological procedures and support groups for women with conditions such as ovarian cancer or endometriosis. There were specialist midwife, for example in bereavement to support women.
- In the children's and young people's services, play workers provided advocacy for children and emotional support. Peer support and social groups were actively promoted with parents and children, in the neonatal intensive care unit. Parents and carers could accompany children to the anaesthetic room and

Summary of findings

stay with them until they were asleep, and were with their child in theatre recovery when they were awake. Families were able to stay close to their children by their bedside during their hospital stay.

- Psychological support was also available. For example, stroke patients had a mood assessment pathway and had appropriate clinical psychological referral and psychology services were available for children and young people living with long-term conditions and receiving specialist services Clinical nurse specialists offered support for specific conditions.

Are services at this trust responsive?

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

Overall we rated the responsiveness of the services at the trust as 'requires improvement'. For specific information, please refer to the individual report Queen Alexandra Hospital.

The team made eight separate judgements on whether services were responsive. Four were judged as 'requires improvement', four in critical care, maternity and gynaecology, end of life care and outpatient and diagnostic imaging services were judged as 'good'. This meant that the trust was delivering responsive services but not consistently and there were areas where standards were not met.

The trust understood the needs of its local population and was planning service change in response to the increasing demand for services. However, the trust had not effectively tackled its most urgent problem, that of increasing number of emergency admissions and patient flow through the hospital. Operation plans were reactive and focused within the emergency department and there was not an improvement plans that focused on hospital wide solutions. The hospitals environment was modern although some areas, unaffected by the private finance initiative, refurbishment and redesign.

Patient's privacy and dignity was respected but there were areas where this needed to improve in the emergency department, the dialysis unit on the Isle of Wight and in the ophthalmology outpatient area.

There was good support for people with a learning disability and for people living with dementia, although dementia care varied across the trust.

Requires improvement



Summary of findings

Patients were not always aware of how to make a complaint and there needed to be better investment in Patient Advice and Liaison Services (PALS) to support patients to raise concerns and issues informally. Complaints were handled appropriately but could take some time to complete.

Service planning and delivery to meet the needs of local people

- The trust understood the needs of the local population and was planning for service change. The socio-economic profile and demographics of the surrounding areas had been analysed and the trust understood the challenge of an ageing population with multiple comorbidities which at present was representing a significant emergency admission problem. The trust had strategic plans to work with partners around integrated pathways of care, particularly for the frail elderly, but these were currently underdeveloped.
- The current challenge of emergency admissions was considered “complex” and somewhat of an inevitability. Crucially there was strategic and operational inertia in planning and responses were focused on managing the immediate and constant service pressures. Some operational changes had occurred, for example, the majors area extension, but these were not well planned and were focused within the emergency department rather than hospital wide solution.
- The trust The trust was identifying some improvement initiatives but did not have a finalised improvement plan for the emergency care pathway at the time of our inspection, and did not have an appropriate escalation plan to ensure patient safety and improve the flow of patients through the hospital, when there was overcrowding - a frequent occurrence - in the emergency department. Its most significant pressure was not being managed appropriately.
- Some services were using information to understand the needs of the local population and services were changing in response to increasing demand, for example, ambulatory care, a GP nurse and nurse practitioners in the surgical assessment unit, and increases in the number of intensive care beds.
- The hospital was newly built in 2009, and many service areas had modern environments and facilities. Some areas (the emergency department and older parts of the hospital that had not been under the private finance initiative) required refurbishment and redesign to improve patient flow and the patient experience.

Meeting people's individual needs

Summary of findings

- Staff across the hospital demonstrated a good understanding of how to make reasonable adjustments for patients with a learning disability. We observed that reasonable adjustments were being made, for example, the use of communication booklets in children's services and to reduce anxiety and provide support for patients having surgery. There was a specialist learning disability nurse and good use of the care passport scheme (a document used by patients with a learning disability to outline their care needs and preferences and information about them for staff to reference). However, the trust did not have an effective system to flag patient with a learning disability who may be admitted or who might attend an outpatient clinic.
- The trust had adopted policies and procedures designed to identify and promote the support of people living with dementia. For example all patients over 75 years were screened on admission using recognised methodology, the 'this is me' booklet was being used to recognise the people's preferences and needs there was a dementia care bundle to provide appropriate support. However, care for patients living with dementia varied, as well as training, assessment, the use of the dementia care bundle and making reasonable adjustments to reduce stress and anxiety. The care needs of people living with dementia were not always met. A recognised symbol was not used to identify people and encourage additional support and the care needs were not always met. The trust did not have a specialist dementia nurse but there was a lead nurse and dementia champions on the wards. Some areas did demonstrate excellent examples of the care such the 'memory lane' service on the elderly care wards. This was held once a week and included engaging patients in remembering their past times by means of music, games, reading material and communication.
- There was an arrangement with the local NHS mental health trust to provide a liaison service for people with a learning disability and mental health disorders. The mental health team worked in the emergency department and inpatient areas. The trust had a mental health specialist midwife and a consultant trained in perinatal mental health problems. The trust however, could not always access specialist support for patients with drug and alcohol problems.
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. However, this was not the case for ambulance patients waiting in corridors in the emergency department and also for patients in the dialysis unit on the Isle

Summary of findings

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

- An interpreting service was available for people whose first language was not English and the service was used. All information for patients was only available in English. In radiology, easy-to-read leaflets were available for patients with a learning disability, where language style had been adjusted and pictures used to explain procedures. We did not see any other information in an easy-to-read format

Access and flow

- Bed occupancy at the trust was 92% (January 2014 -March 2015), consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.. Adult critical care was at 82.4% bed occupancy – below the England average of 83.2%.
- The trust had described an increasing number of emergency admissions and significant and enduring pressures on the emergency care pathway. The impact of this was being felt throughout the trust. Ambulances were waiting longer to admit patients and “queueing” ambulances were a problem at times. Though infrequent, some patients were held in a large ambulance (called a “Jumbulance”) outside of the emergency department (ED) which was a completely inappropriate environment for sick patients. Patients were not being assessed and treated within standard times in the emergency department and the trust was not meeting the emergency access target for 95% patients to be admitted, transferred or discharged within four hours. This target had not been met since November 2013.
- Patient flow throughout the hospital was a significant concern and patients had lengthy waits for an inpatient bed and, at times of peak demand, many waited on a trolley in the corridor. The trust had a significant number of patients that breached 12 hour waits and patients were waiting in the ED up to and over 14 hours. The ED did not always prioritise patients for beds based on their clinical needs.

Summary of findings

- Many inpatients, particularly medical patients were not on specialists wards and during the inspection, there were 59 medical outliers (patients placed on wards other than one required by their medical condition). These patients were not always regularly reviewed by medical consultants.
- Patients could be moved several times during their admission. This happened at night and for non-clinical reasons. The trust identified that older patients, patients with high dependency and acuity needs and end of life care patients should not be moved. However, older patients, including patients who were confused, or living with dementia and who may have had complex conditions, were being moved.
- The critical care unit experienced discharge delays out of hours and delays to admission because of pressure on beds in the hospital. There were a higher number of patients discharged overnight than in similar units. The Core Standards for Intensive care 2013 detail that historically discharges from critical care services overnight have been associated with excess mortality and a poor patient experience. The unit had taken action to mitigate risks and this included comprehensive discharge summaries and a retrieval team who care for patients on the ward while they waited for admission.
- The trust was not meeting the referral-to-treatment time targets for 90% of patients to start treatment within 18 weeks of referral. Because of high demand for emergency surgery, elective procedures were increasingly being cancelled. Some patients told us their operations had been cancelled several times, although the majority did go on to have their surgery within 28 days.
- The trust was meeting the cancer waiting time targets overall. The target for referral to treatment within two months had not been met in January 2015. Most patients had timely outpatient follow up appointments but some patients, in colorectal surgery, orthopaedic and gastroenterology and ophthalmology specialties had longer waiting times. The ophthalmology waiting time had been identified as a serious risk for the trust and action was being taken.
- Patients experienced discharge delays on their expected day of admission, for example, waiting for medication but the trust had worked effectively with partners to reduce the number of discharge delays for patients waiting for nursing home places, waiting for social care arrangements, and patient/family choice.

Summary of findings

Data published by NHS England (December 2014 to January 2015) demonstrated that the trust had a comparatively smaller number of delayed discharges compared with other similar trusts.

- There was a rapid access discharge service within 24 hours and the number of patients discharged to their preferred place and who were able to die at home was higher than the national average.

Learning from complaints and concerns

- During 2013/14 the trust handled a total of 691 complaints. This was an increase by 30% compared to the previous year. The top five themes were similar to the NHS and these were clinical treatment (including delayed diagnosis), delayed admission, transfer or discharge, staff attitude, appointment delays or cancellations and communication. All but two complaints were acknowledged within the Department of Health 3 working days expected timeframe.
- Over the same time period, the trust had had a corresponding decrease in the number of contacts to the Patient Liaison and Advisory Service (PALS). Patients told us that PALS were not visible and this was increasing formal action rather than trusting local discussions and informal resolutions. The trust was reviewing, and reinvesting, in the work of PALS in an effort to cultivate a more proactive approach to concerns by undertaking the following: reinstating the drop-in office within the main reception area allowing an opportunity to have problems resolved on the spot; ensuring there is a PALS officer available during core hours to offer advice and support; providing better signage for the PALS area within main reception; PALS regularly visiting our inpatient areas and speaking with patients and relatives.
- The trust did not have an overall timeframe to respond to complaints to ensure consistent and prompt responses. The trust also did not record the number of days to complete a complaint. Data reviewed from 1 April 2014 to 30 November 2014 demonstrated that complaints were taking on average between 2 to 3 months to complete. The trust was not monitoring open and overdue complaint cases to improve the timeliness of response. The trust, had only introduced the monitoring of complaint outcomes (ie whether they were upheld or not) in April 2014. The findings were that 65% were upheld and the trust now required each clinical service centre to devise and implement and improvement plan.

Summary of findings

- We reviewed three recent complaints. These complaints were responded to according to guidelines and there were adequate details and clarity on the lessons learnt.
- During 2013/14 the Parliamentary and Health Service Ombudsman (PHSO) had 14 complaint contacts from the trust. This was only a slight increase from the previous year (which was 13). One case was under review but 10 cases were not upheld and only three were upheld or partially upheld. This meant that most complaints were being effectively resolved through the trusts' complaints handling process.
- Information from complaints was reviewed and acted on; although some patients told us they were not always given information about how to make a complaint.
- The trust had plans to survey complainants, produced new information leaflets, develop staff training and improve data recording. This was being done to take action on the lessons learnt from complaints, for example around staff attitude and in order to improve access to complaints services and improve how complaints were handled.

Are services at this trust well-led?

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 trust had a three year strategy that aimed to deliver high quality patient care, working in partnership and supporting innovation in healthcare. There was a focus on emergency care with plans to transform services to reduce admissions to hospital and deliver care closer to home. However, many of these priorities were underdeveloped and the trust was dealing with the immediacy of capacity issues. Clinical services did not have joined up strategies and did not work effectively to support the flow of patients through hospital.

The leadership team was in the process of change and development. There was the commitment to improve and deliver excellent services, but there were gaps in operational performance and delivery, particularly around the unscheduled care pathway. The trust had worked with the wider health economy but did not have clear plans to deliver service improvements and had not effectively delivered consistent improvement. There was a wide

Requires improvement



Summary of findings

variation in the quality and safety of services across the trust, although many services were good or outstanding some areas of performance failures were not appropriately recognised. There had not been a recent formal assessment of the board's performance.

The trust had all the elements of an effective governance framework but these were not being used effectively. There was a comprehensive integrated performance report to benchmark quality, operational, financial and workforce information and each clinical service centre had a quality dashboard. However, some risks were not identified and the action taken on known risks did not always mitigate these and were not always timely. Some risks had been on risk registers for several years without a clear resolution of the mitigating actions or a monitoring statement for risks that cannot be fully mitigated.

We served two warning notices for the trust failure to respond to patient safety issues, and the failure to effectively assess and manage the risks to patients in the emergency department.

Staff were positive about working for the trust and the quality of care they provided. The trust was similar to other trusts for staff engagement, but its staff survey had demonstrated year on year improvement. The trust 'Listening into Action' programme had demonstrated changes and improvements to services based on staff innovations. The staff had a strong sense of identify that was focused on care.

There was a focus on improving patient experience and public engagement was developing. Safety Information was displayed in ward and clinic areas for patients and the public to see.

The trust had a culture of innovation and research and staff were encouraged to participate.

Cost improvement programmes were identified but savings were not being delivered as planned and the trust was having to take further action to reduce the risks of financial deficit. .

Vision and strategy

- The trust clinical strategy 2012/13 to 105/16 was reviewed in March 2014. The strategy identified the vision of the trust "To be recognised as a world-class hospital, leading the field through innovative healthcare solutions focused on the best outcome for our patients delivered in a safe, caring and inspiring environment".
- The aim of the strategy was to meet the needs of the population served and to transform services with a particular focus on unscheduled care, care of the frail and elderly and

Summary of findings

long term conditions. The strategy described working with partners, profitability to be able to invest, providing 24/7 care, and driving quality through research, training and innovation. There was an emphasis on clinical services developing integrated models of community care which will enable a significant proportion of patients, spanning every age group to receive high quality care closer to home. The trust planned to deliver general, specialist and tertiary services.

- The core priority for the trust was unscheduled care and the strategy described mechanisms to reduce admissions, redesigning the emergency flow within the hospital, both adult and paediatric, extend the number of Ambulatory Care pathways, and creating a range of Integrated Care Pathways. There had been some progress in models of ambulatory care and 24/7 working. However, many of the areas described were undeveloped and uncoordinated across the trust. There was not evidence of effective strategies supported by plans to deliver improvements in patient care.
- The clinical services did not have clear written strategies but most had identified priorities in response to capacity issues, demand and the trust clinical strategy. Service development varied across the trust and was focused within clinical service centres. Many staff were not clear about their role in delivering the strategy in their service and across the trust. There was not a structured approach to service redesign, trust wide operational planning and integrated pathways of care.

Governance, risk management and quality measurement

- The trust quality governance structure was managed through the governance and quality committee which reported to the trust board. Operational performance and delivery was managed through the senior management team that reported to the trust board. There were groups to manage specific areas of governance, such as medicines management, safeguarding, or serious incidents requiring investigation. Governance arrangements were devolved to the trusts clinical service centres. These service centres held monthly multi-disciplinary governance meetings to review quality, risks and operational performance
- The trust quality improvement strategy 2014 -17 was agreed in September 2014. The strategy had three core elements to provide safe and reliable care; Improve patient experience; and improve clinical effectiveness and outcomes. The trust produced quarterly quality reports covering which included indicators, for example, on avoidable harms, clinical outcomes, mortality, participation in national audits and friends and

Summary of findings

family test. Clinical service centres had quality dashboards, which included similar indicators though these were reduced in number and were less specific. These dashboards were in development and did not currently include specific ward based figures, for example, on clinical outcomes, avoidable harms or training. There was infection prevention and control dashboards which covered ward level information. The action taken for indicators which were not being met was not always clarified and evaluated in reports.

- The trust had an integrated performance report which the board reviewed monthly. This included data on performance, quality, finance and the workforce. The information was collated at a trust wide level. The board did not have sub-committee to review operational delivery. Trust board papers were comprehensive but were numerous, detailed and covered the range of strategic and operational priorities.
- The trust corporate governance arrangements were well developed. Papers were well structured to determine issues and actions risk. However, the challenge, assurances and actions agreed and taken by the board in response to key issues, were not always clear.
- The corporate risk register included clinical, organisational and financial risks, and used likelihood and impact/severity criteria for risks to develop a ratings score. The board assurance framework was monitored monthly. This was used to identify the top strategic and operation risks and there was a predictive tool to identify and provide assurance on actual, anticipated, and potential risks. Though the board assurance framework was well developed the intelligence was underdeveloped and some areas were incomplete. The assurance framework was not being used to identify progress against strategic aims. Risks were being plotted but mitigating actions and controls did not always have the desired effect and there was not the evaluation to address issues, for example, some risks remained on target despite the current risk level increasing.
- There were issues affecting quality in the trust's relationship with Carillion, for example, the monitoring of maintenance works, but these had not been addressed in governance arrangements
- Clinical service centre risk registers did not always identify the risks and concerns of staff, Known risks were escalated to the corporate risk register. Mitigating actions and controls were detailed in many areas but these were not always clearly defined and the action taken was not timely. Some risks had been on risk registers for a number of years without clear

Summary of findings

resolution. These issues were apparent in the emergency department, medical, surgical and outpatient services. Safety Information was displayed in ward and clinic areas for patients and the public to see.

- The trust had not used clinical audit and internal audit in a coordinated way to review governance arrangements or provide the appropriate breadth and detail around assurance and risks.
- We served two warning notices for the trust failure to respond to patient safety issues in the emergency department and the failure to effectively assess and manage the risks to patients.

Leadership of the trust

- The trust had had stability with a Chief Executive Officer having been in post for 12 years. However, there had been some significant changes to the trust board leadership team over the last 18 months. The Chair was relatively new and had only joined the trust in June 2014 and there was also a new Chief Operating Officer and Director of Nursing in January 2015. The leadership was in the process of change and development. There was the commitment to improve and excel and some directors were clear about their portfolio and areas of action. However, there were gaps in delivery in terms of the performance and operational management.
- The non-executive directors (NEDs) had a broad range of experience. The NED had an understanding of, and commitment to, the safety and quality agenda and were supported to develop their roles. However, the NEDs were not always informed on key trust issues or how the trust was working to resolve key areas of risk. Consequently, there was a lack of rigour in some key challenges and assurances obtained from the board.
- The current Chairman had conducted an assessment of the board after joining the trust to identify capacity and skill shortages. As a result, two new NED and executive director appointments were made. The trust did not have a board development programme to ensure the leadership team was working effectively and there had not been a recent formal assessment of the board's performance. This would be important to ensure sustained improvement.
- The trust had an active and well-structured council of governors whose remit was to advise on the trust's strategic direction, develop trust strategy and to act as guardians of the trust for the local community. The trust had joint board and council of governors meeting and the council described

Summary of findings

working with the trust in open and transparent way. Though initially dissuaded, governors now participated in walking the wards and talking to patients. The council of governors led a number of trust advisory groups on best hospital, people and care and planning and performance and had been effective in identifying key issues and improving services. For example, they acted as a critical friend in outpatients and this had led to improvements. However, it was not a model that was being updated elsewhere.

- The leadership team were clear about the strategic direction of the trust, but did not have clarity about how to manage current challenges. The trust had not appropriately recognised some key performance failures or provide leadership to address the issues. There had been strategic work across the wider health economy and this included an independent review in May 2014 to develop an action plan. However, although there was a commitment to resolve issues, this had not been addressed in a timely way. There was an identified 'blind spot' around the challenge of responding to emergency admissions. The problem was seen as "complex" and inevitable based on the local population demographics and it had become clinically acceptable, and part of normal practice, to have patient's queueing in corridors or in ambulances awaiting admission. Staff were aware of the need for change but in some areas felt powerless to respond, and there were not clear pathways of care across clinical service centres, for example, for a coordinate emergency care pathway.
- Many services identified good local leadership but some areas identified the need for more support, this was particularly the case in the emergency department and in some ward areas. Clinical engagement needed to improve across the hospital and there was a lack of clear accountability in some areas about failures in the quality of care.

Culture within the trust

- The values of the trust were described as "Best hospital, best care, best people". All staff in all areas were aware of the values of the trust and many staff verbalised, and demonstrated, their passion and the committed to ensuring the quality of the service they provide. There trust had a strong ethos of patient centred care. There was a strong sense of team working and staff had a collective responsibility for quality. Staff told us about an openness and transparency about when things go

Summary of findings

wrong and staff were supported to report incidents, and to openly discuss openly what they did not know. There were, however, a few areas where staff felt unsupported to be open about concerns.

- Where the trust had identified concerns about leadership and team working, for example, within the colorectal surgery team, these were being handled appropriately.
- The trust's clinical service centres were separately managed units and operationally, there were significant gaps in joined up working. This was particularly evident across the emergency care pathway where escalation procedures were not effective across services to improve the flow of patients in the hospital. Staff also identified difficulties in coordinating referrals for patients with complex conditions.
- The NHS Staff Survey 2014 identified that the trust was similar to other trusts for staff engagement but was in the top 20% of trusts for staff reporting good communication with the senior management team. The staff survey indicated a sustained increase in result compared to previous years across all areas. Staff were positive about the visibility and support of the Chief Executive and many staff at all levels told us they were proud to work for the trust. Many staff had worked in the trust for a number of years, some for their entire careers and some having returned from other jobs. They pointed to the specific culture in the trust where staff, particularly those in leadership roles were open and accessible. A few staff indicated a concern that some leaders in the trust sometimes expected immediate results and this could often be difficult and challenging when working under pressure.
- Feedback from commissioners, stakeholders was that there had been previous difficulties but that relationships had improved and the trust was generally working positively with its partners. While the trust was generally described as open and transparent, it had not actively encouraged appropriate external representation on its key quality committees both from representatives of patients and from other providers, commissioners and stakeholders. Many stakeholders could not understand why the trust was continuing to experience the level of difficulty with its emergency care pathway and why this had not improved at a more rapid pace.

Fit and Proper Persons Requirement

Summary of findings

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) to ensure that directors of NHS providers are fit and proper to carry out this important role.
- The trust had undertaken an audit of executive and non-executive directors in November 2012. There were gaps in evidence on person files, for example, evidence of qualifications. These were reported as updated in January 2015.
- The board agreed the FPPR for executive and NEDs in January 2015 and specifically agreed that directors following actions. There to be :
 - Additional pre application question for director posts asking if they have been sent to prison in the last 5 years.
 - Directors also complete a Fitness to Practice form following offer of a position when they declare any previous convictions.
 - Reference request to be amended to specifically request confirmation the director is a fit and proper person under the regulations definition.
 - Undertake a free check against the list of Directors which is held by Companies House to verify if a director has been barred as a director or is subject to any restrictions.
 - Undertake a credit check on every appointment
 - Amend the contract of employment permitting summary termination in the event of a director being/becoming an unfit person.
 - Introduce a process of annual self-declaration for all Directors to be undertaken in January each year. To be confirmed during annual appraisal.
 - Non-Executive Directors to undergo an annual appraisal.
- We reviewed two personnel files of directors who had recently been appointed. These had had the relevant checks.

Public and staff engagement

- The trust was similar to other trusts for in the NHS staff survey 2013, but most indicators had shown an improvement in previous years. The trust only had three negative indicators and these were for staff agreeing that their role makes a difference, staff reporting errors, near misses and incidents and staff feeling pressure to attend work when feeling unwell.
- Most staff in the trust were positive about engagement. Many mentioned the positive impact of the trust 'Listening into Action' initiative where staff shared their views about what

Summary of findings

would make the biggest difference to services. Themes were identified regarding 'what matters to staff' and 'making things better for patients' and action was taken to improve services. Over the past two years, the trust could demonstrate changes and improvements to services based on staff innovations. For example, reduction in theatre equipment wastes, 20% reduction in delayed x-rays, Patient safety issues and 'human factors' training, portering journeys reduced from 230 to 50 per month, centralised referral document improving the speed of internal patient referrals, and phlebotomy handover to junior doctors to minimise missed bloods and errors.

- The trust hold annual Best People Awards and the Chairman Awards to recognise staff achievement. There is also an employee of the month. Staff feedback on these awards was positive. Staff health and well-being was supported and the hospital had a specific centre, called the Oasis Centre, which provided sport and relaxation facilities for staff.
- Many staff told us communication was good across the trust. There was a trust newsletter called 'Trust Matters', the intranet, and teams held regular meetings to support staff engagement. In the critical care unit staff had secure Twitter and Facebook accounts to improve communication.
- The trust had a patient experience strategy was part of the quality improvement strategy and there were two main aims: to demonstrate improvements in patient experience through the Friends and Family Test; and to improve and act upon local patient and family feedback, with a focus on the cancer pathways, dementia care and the discharge process. There was a patient experience steering group to review progress and this group reported to the Governance and Quality Committee. Quarterly reports monitored how information was captured and used to improve services and there were performance indicators for example, on the Friends and family test, mixed sex accommodation and complaints. The trust was in the top 20% of trusts for friends and family test and could demonstrate actions on patient feedback.
- There were examples of patient and public engagement in services, for example, focus groups held by clinical nurse specialists, the memory café for patients with dementia and the dementia café for carers and the trust website was straightforward and accessible. There was partnership working with the Alzheimer's Society, Osteoporosis Society and Solent

Summary of findings

MIND dementia carers. There was less evidence of an overall engagement strategy to plan around open days, community working, partnership working with vulnerable groups, newsletters and the use of social media.

Innovation, improvement and sustainability

- The trust commissioning for quality and innovation (CQUINS) priorities included dementia and delirium outcomes, improving response rate to the Friends & Family Test and patient experience metrics. The trust was demonstrating improvements in these areas. The trust however, had been fined by commissioners for not meeting the emergency access four hour waiting time target.
- The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. There were many examples of service improvements developed by the trust and the staff. The trust could demonstrate staff recipients of local and national awards. These award covered research, innovation, education and training.
- The trust's performance was monitored by the Trust Development Authority. As part of its progress to foundation trust status shadow risk ratings are used that are identified by the health regulator Monitor. Risks around the emergency access four hour target, waiting times and c.difficile infections has given the trust a shadow risk rating for service performance of 3 (Amber – Red) and governance risk rating of above 4 (Red), where red is high risk.
- During the year 2014/15, the trust position has forecast a financial deficit of £4.3m. Financial pressures were exacerbated by emergency admissions and staffing costs. The trust was not achieving its cost improvement targets and only 62% had been delivered (a shortfall of £2.3m) had received financial penalties for not meeting performance targets, namely the emergency access target and discharge summaries to GPs. The board but had agreed a range of financial measures and was expecting to make a small surplus of £1.2m this year. The measures were to improve efficiency, clinical coding so that the trust could be appropriately paid, have a temporary reduction in staffing where minimum levels were appropriate, reduce penalties and provide further support and challenge to the clinical service centres around cost improvement plans. The risks around these initiatives were on the trust risk register and board assurance framework in terms of failure to deliver but the quality and safety implications were not identified here and had not been to the trust governance and quality committee.

Summary of findings

- The trust could demonstrate investment in new technology and the use of national resource schemes, for example the trust had been successful with the national “Safer Wards, Safer Hospitals Technology Fund” and the Nurse Technology Fund and was investing in electronic monitoring and reporting and bed management technology for nurses.
- Income was also being generated through research and innovation and teaching. The trust had a research and development department to manage and coordinate research activity and worked in partnership with the local Universities, the Clinical Research Network, the Academic Science Health Network and others develop research with all staff groups.

Overview of ratings

Our ratings for Queen Alexandra Hospital

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

Our ratings for Portsmouth Hospitals NHS Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

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

Outstanding practice and areas for improvement

guidance, tutorials and podcasts from recognised intensive care organisations, Portsmouth intensive care staff and other intensive care staff about the use of intensive care equipment and procedures. This was accessible to staff, staff from other trusts and the general public.

- A perineal clinic had been designed and implemented to provide outpatients care and treatment to women who had sustained third- and fourth-degree tears following delivery. This service enabled women to access treatment sooner than under previous systems. Staff also provided treatment, support, information and education to women who had experienced female genital mutilation.
- There was a telephone scheme for women who had experienced complex or traumatic deliveries to talk about and have a debrief conversation with a midwife following their discharge. The outcomes from the conversations were used as part of the governance processes and this demonstrated a reduction in the number of complaints.
- A mobile telephone application (app) had been developed by the trust and the Chair of the Midwife Liaison Committee together with women who used the services. The app provided information on choices of place of birth and was being developed to include additional information. The app won an award from NHS England in the excellence in people category and the service had also been recognised with an innovation award from Portsmouth Hospitals NHS Trust.
- The multidisciplinary team in the children's and young people's services had made a commitment to creating

an open culture of learning, reflection and improvement. This included listening to and empowering and involving staff, children, young people and their families. We found all staff, at all levels, were involved in working towards this goal and this was having a positive impact on improving the safety and quality of services for children, young people and their families.

- There was a new initiative called a 'talent panel', which was a mechanism to discover and develop staff, both for individual career development and the future sustainability of the service. Staff of all grades were encouraged to submit their career aspirations to a panel so that steps to support them could be identified.
- The trust had introduced a volunteer programme for people who wanted to work as a chaplain's assistant. Volunteers were trained on how to support patients through visiting them. Through this training programme, the trust had over 50 volunteers coming to help and support patients.
- The trust received a national award for clinical research impact. The award recognised the trust "Research in Residence Model" and its ability to harness clinical research to improve services and treatments for its patients. The trust identified the development of the early warning system, mobile application for pregnant mothers (cited above), and developing methodologies to reduced respiratory exacerbations and admissions and detect upper and lower gastrointestinal cancer more effectively.

Areas for improvement

Action the trust MUST take to improve

Action the hospital MUST take to improve

- Patients are appropriately assessed and monitored in the emergency department (ED) to ensure they receive appropriate care and treatment.
- Ambulance patients are received and triaged in the ED by a qualified healthcare professional.
- There are effective system to identify, assess and manage the risks in the ED.
- There is an adequate supply of basic equipment and timely provision of pressure-relieving mattresses.
- The cardiac arrest call bell system in E level theatres is able to identify the location of the emergency.
- Medication is prescribed appropriately in surgery and is administered as prescribed in gynaecology.
- The emergency resuscitation trolley on the gynaecology ward is appropriately checked.
- Appropriate standards of care are maintained on ward E3 and the acute medical unit.

Outstanding practice and areas for improvement

- There is a hospital wide approach to address patient flow and patient care pathways across clinical service centres.
- Patients' bed moves are appropriately monitored and there is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night, several times and for non-clinical reasons.
- Patients are allocated to specialist wards, when clinical need requires this, and medical outliers are regularly reviewed by medical consultants.
- Nurse staffing levels comply with safer staffing levels guidance.
- There are adequate numbers of medical staff on shifts at all times.
- All wards have the required skill mix to ensure patients are adequately supported by competent staff.
- The falls action plans are followed in a consistent way across the medical services.
- There is compliance with the WHO Surgical Safety Checklist.
- Staff awareness of standard protocols or agreed indicators for pre-assessment improves to support them in making decisions about the appropriateness of patients for day case surgery.
- Staff on all wards are able to raise concerns above ward level, particularly when this impacts on patient care, and there is a response to these concerns.
- Discharge summaries are sent out in a timely manner and include all relevant information in line with Department of Health (2009) guidelines.
- Staff observe recognised professional hand hygiene standards at all times.
- The surgical high care unit is risk-assessed for infection control risks.
- Medical and dental staff complete mandatory and statutory training.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Nursing handovers provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met.
- Nursing staff are appropriately trained in the safe use of syringe drivers.
- All pharmacists have an appropriate understanding of insulin sliding scales and where such information should be recorded.
- Patient confidentiality is protected so that patients and visitors cannot overhear confidential discussions about patients' care and treatment.
- Records are kept relating to the assessment and monitoring of deteriorating patients in recovery.
- Patient records and drug charts must be complete and contain all required information relating to a patient's care and treatment.
- Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.
- Patient records are stored so that confidentiality is maintained.
- The trust fully participates in all national audits for which it is eligible on end of life care.

Action is taken to improve the leadership where there are services and ward areas of concern.

At a trust level:

- The trust clinical strategy is supported by clear improvement plans and these are monitored and evaluated appropriately.
- Governance arrangements are managed effectively so that there is appropriate assurance around risk and performance.
- The trust board has a development programme and there should be appropriate and timely assessment of its performance.
- There is continued investment in PALS.
- Complaints are appropriately monitored and responded to in a timely manner.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 HSCA Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service.</p> <p>The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe.</p> <ul style="list-style-type: none">• The medical outliers were not regularly reviewed by medical consultants.• Patients were not allocated to specialist wards according to their clinical needs.• Nursing handovers did not provide sufficient information to identify changes in patients' care and treatment and to ensure existing care needs are met. <p>Regulation 9- 1 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p> <p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.</p> <p>The provider did not have effective systems to regularly assess and monitor the quality of services provided.</p> <ul style="list-style-type: none">• Patients were not appropriately monitored and were moved several times and at night and for non-clinical reasons.

This section is primarily information for the provider

Compliance actions

- Staff were not aware of standard protocols or agreed indicators for pre-assessment improve to support them in making decisions about the appropriateness of patients for day case surgery.
- Some nursing staff on wards did not feel safe in raising concerns above ward level.
- GP discharge summaries were not being sent out in a timely manner and did not include all relevant information in line with Department of Health (2009) guidelines.
- The surgical high care unit had not had a risk assessment for infection control risks.

Regulation 10 (1) (a) (b) (HSCA 2008 (Regulated Activities) Regulations 2010.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.

The provider did not have suitable arrangements to protect patients and staff against the risk of unsafe equipment or the lack of availability of equipment.

- There were inadequate supplies of intravenous pumps, drip stands, pressure-relieving mattresses and other equipment.
- The cardiac arrest call bell system in E level theatres was unable to identify the location of the emergency.

Regulation 16 1 (a) (2) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20. HSCA 2008 (Regulated Activities) Regulations 2010 Records.

Compliance actions

The registered person must ensure that the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of – (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

- The falls action plans were not followed in a consistent way across the medical services.
- Compliance with the WHO Surgical Safety Checklist was not documented appropriately.
- Records relating to the assessment and monitoring of deteriorating patients in recovery were not kept.
- Patient records and drug charts were not complete and did not contain all required information relating to a patient's care and treatment.
- Patient records were not always stored so that patient confidentiality was maintained.
- Do not attempt cardiopulmonary resuscitation forms were not completed appropriately.

Regulation 20 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff at all times.

- Nurse staffing levels did not comply with safer staffing levels guidance.
- All wards did not have the required skill mix of staff to ensure patients are adequately supported by competent staff.
- Medical staffing levels were not as recommended.

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

This section is primarily information for the provider

Compliance actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations
2010 Supporting staff

Regulation 23: HSCA 2008 (Regulated Activities)
Regulations 2010: Supporting Workers.

- Medical and dental staff did not meet trust targets to complete mandatory and statutory training.
- Nursing staff did not receive formal clinical supervision in line with professional standards.
- Nursing staff did not have appropriate training in the safe use of syringe drivers.

Regulation 23 1(a) Health and Social Care Act 2008
(Regulated Activities) Regulations 2010.

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 HSCA Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people using the service.</p> <p>A warning notice was served under Regulation 9 1 (a) (b) In the Emergency Department</p> <p>Patients brought to the emergency department by ambulance were at risk of unsafe care and treatment. The trust had failed to take proper steps to ensure that each service user is protected against the risk of receiving care or treatment that is inappropriate by the means of carrying out an assessment of the needs of the service users and planning and delivering care in a timely way to meet the individual service user's needs. The trust did not take proper steps to ensure the welfare and safety of service users.</p> <ul style="list-style-type: none">• National guidance was not followed in the triage and assessment of patients.• A national target had been set that states that ambulance patients should be handed over to the care of emergency department staff within 15 minutes. Figures sent to NHS England showed that the average waiting time to initial clinical assessment by the emergency department at Queen Alexandra Hospital was 25 minutes.• Patients waiting in corridors did not have appropriate monitoring and observation.• Patients who did not receive clinical assessment within 15 minutes were not receiving care or treatment to meet their individual needs and to ensure their welfare and safety. Some patients with serious conditions had been waiting over 60 minutes.• A non-healthcare professional was being used to triage patients.

Enforcement actions

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

Regulation 10 HSCA Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision

A warning notice was served under Regulation 10 1 (a) (b) 2 (c) In the Emergency Department

- The trust's identified problem with flow had been on the risk register since November 2014.
- The recommendations from the Emergency Care Intensive Support Team report (May 2014) had not been implemented. There was a draft and incomplete action plan in August 2014.
- The emergency access target was not met and was identified as a major risk on trust risk registers.
- Escalation plans did not have sufficient triggers and actions to manage the problems with flow in the emergency department.
- The trust had not clearly defined the responsibility with the ambulance service for patients on hospital grounds and patients were at risk.
- Staffing levels had not been reviewed in line with changes made to the department.
- Changes to the department had been introduced that did not meet national guidance (a healthcare assistant triage process).
- At our unannounced visit no progress had been made following the inspection.
- The trust had introduced a method to monitor assessment but the process made staff feel 'pressurised' and provided false assurance.