Care Quality Commission

Hampshire Hospitals NHS Foundation Trust

Royal Hampshire County Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

Royal Hampshire County Hospital (RHCH) is one of the acute district hospitals, and is based in the city of Winchester, Hampshire. The hospital has approximately 457 beds, and they had 44,273 emergency attendances in ED, and 211,418 outpatient attendances last year.

The RHCH provides a full range of general hospital services including accident and emergency, general and specialist surgery, general medicine, maternity and gynaecology, intensive care, rehabilitation, chemotherapy, diagnostic services, out-patient clinics and paediatric care.

The hospital employs approximately 654 clinical staff. They do not outsource for any contracted staff, and non-clinical staff are employed in all of the support functions such as portering, facilities management and catering provision.

We undertook this inspection of Hampshire Hospitals NHS Foundation Trust as part of our comprehensive inspection programme. The trust was in priority band 6 according to our Intelligent Monitoring system (with band 1 being the highest risk and band 6 being the lowest risk).

The inspection of RHCH took place on 28 to 31 July 2015. The full inspection team included CQC senior managers, county managers, inspectors and analysts. Doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers also joined this team.

We reviewed the following core services provided at RHCH: urgent and emergency care, medical (including older people's) care, surgery, critical care, maternity and gynaecology services, children and young person's services, end of life care, and outpatient and diagnostic services.

Overall, we rated RHCH as 'good'. We rated it as 'outstanding' for providing caring services, and good for safe, effective, responsive, well-led care.

We rated all services as RHCH as 'good' with end of life care as an 'outstanding' service.

Our key findings were as follows:

Are services safe?

- Staff were encouraged to report incidents and there was learning from incidents to improve the safety of services locally and across the trust.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission
- Clinical areas, such as wards, theatres and clinics were visibly clean with appropriate cleaning schedules.
- Staff followed infection control procedures and these were monitored. Staff in some areas were working to improve hand hygiene practices and environmental infection control standards, after having done audits.
- Medicines were appropriately managed and stored. However, fridge temperatures were not being regularly checked and monitored on the surgical wards.

Summary of findings

- Anticipatory medicines (medicines prescribed for the key symptoms in the dying phase ie pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness) were prescribed appropriately.
- Equipment was checked and stored appropriately in most areas but this needed to improve in surgery and on some medical wards specifically for resuscitation equipment.
- Overall, staff had a good understanding of safeguarding adults and children although more staff needed to attend training.
- More staff needed to complete mandatory training.
- Patients' were assessed and monitored appropriately, for example, risk assessments were complete. However, the early warning score needed to be used consistently in surgery, and a tool was required for outpatients, for patients whose condition might deteriorate.
- The hospital had a higher than expected number of avoidable harms (pressure ulcers and falls) against their own targets. The trust was taking action to improve this, for example, care bundles were introduced to appropriately assess and treat patients.
- Critically ill children attending the emergency department were immediately referred to a paediatrician. There was a protocol for the transfer of critically ill children to a specialist care from the Southampton and Oxford retrieval team (SORT). The SORT team would provide specialist staff to support the child during the transfer.
- Medical staffing levels across the hospital were appropriate. National recommendations were followed, for example, for consultant presence in the emergency department, maternity, critical care and end of life care. There was consultant presence in the hospital over seven days with the exception of surgical services; there was 24 hour consultant cover arrangements across all services. Consultants in children and young people services were working additional sessions because of vacancies with junior doctors at middle grade level. This additional working was not sustainable in the long term.
- Nursing staffing levels were identified at trust level using an appropriate acuity tool. Planned staffing levels across all areas were higher than minimum recommendations. The hospital had a significant number of vacancies particularly in medical and older people's care, surgery and children's and young people's services. Staffing levels were monitored and action was taken to fill vacancies from bank staff. Agency staff were not used. However, some medical and surgical wards did not always meet safe staffing levels. Nursing staff were coping by working longer hours, sharing staff or staff skills across shifts. Patients on these wards told us their needs were being met. The trust was implementing actions to mitigate and reduce the risks, for example, by developing skills in health care assistants and having ongoing recruitment campaigns, including employing staff from overseas.
- Midwifery staffing levels did not meet national recommendations but staff worked flexibly and could provide one to one care for all women in labour.
- Radiographers worked alone overnight covering imaging services for the hospital and the emergency department. Radiographers reported a heavy workload and raised concerns over manual handling issues. Between 10.00pm and 8am, radiology was supported by an overnight outsourced radiologist service. Staff identified delays in the process to authorise request and provide advice on imaging which meant delays in the patient diagnosis.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting system. Senior staff we spoke with were aware of duty of candour and talked about the importance of being open and transparent with patients and their families.

Summary of findings

Are services effective?

- Staff were providing care and treatment to patients based on national and best practice guidelines. In some areas guidelines had been unified across the trust for consistency of care.
- Services were monitoring the standards of care and treatment. Patient outcomes were similar to or better than the England average. There were action plans to address where outcomes were worse when compared to the England average.
- Patients who had suffered a stroke would be taken to the Royal Hampshire County Hospital as this was the designated receiving unit for the specialist treatment of stroke in Hampshire. For October 2014 to December 2014, the hospital performed better than other trusts for meeting standards for specialist assessments, thrombolysis and provision of physiotherapy and occupational therapy and discharge processes. The hospital was similar to other trusts for care on the stroke unit, multi-disciplinary working and standards of discharge standards. The hospital performed significantly worse than other trusts in providing speech and language therapy and scanning.
- Patients received good pain relief across all services.
- Patients, particularly older patients, were supported to ensure their hydration and nutrition needs were met.
- Staff were supported to access training. Many staff had a high level of competency having undertaken specialty specific qualifications. There was evidence of regular staff appraisal, although clinical supervision varied.
- Staff worked effectively in multidisciplinary teams to centre care around patients. This included working with GPs, community services, other hospitals. There were innovations in electronic records and the use of video conferencing in end of life care that enabled information to be shared about patient's clinical needs and preferences across the trust, and with community and GP services. However, paediatric inpatient physiotherapy was not sufficient for children and young people with Cystic Fibrosis and this was of concern.
- Seven-day services were well developed, particularly for emergency patients. There was support from therapists, pharmacy and diagnostic services was less well developed.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission. However, capacity assessments were not always documented or regularly reviewed in patient care records.
- 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were not always appropriately completed and did not include, for example, an assessment of the patient's mental capacity.

Are services caring?

- Staff were caring and compassionate and treated patients with dignity and respect. There was a culture in the hospital of understanding and responding to patient's individual needs. This covered clinical and non-clinical staff such as porters who recognised the importance of their role in providing good quality care.
- Patient feedback was overwhelming positive across all services.
- We observed outstanding care for critical care patients, children and young people, patients having end of life care and patients attending outpatient and diagnostic imaging services. The staff had an ethos of providing person centred care and developed trusting relationship with patients and their families.
- Staff maintained patient's confidentiality, privacy and dignity in all areas, although the layout of bay areas in Victoria Ward may have compromised patient's dignity at times
- Patients and their relatives felt involved in their care and treatment, staff provided information and explanations in a way patients could understand. Patients felt that their views and considerations were listened to and acted upon.
- Records of conversations were detailed on patient records. 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

Summary of findings

- Patients and their families were supported by staff emotionally to reduce anxiety and concern. There was also support for carers, family and friends for example, from the chaplaincy, bereavement services for patients having end of live care, and counselling support where required.
- Data from the national surveys demonstrated that the hospital was similar to other trusts. Patients were very satisfied and would recommend the care they received.

Are services responsive?

- Services were being planned to respond to increases in demand, staff capacity and patient needs. There was some innovation in models of care, for example, ambulatory care and early supported discharge. There was also joint work with partners, for example, to in-reach services for psychiatric assessment. Children's and young people services had reduced the number of beds to respond to staffing issues. Other areas were working on how to increase capacity.
- Bed occupancy in the hospital was below the England average of 88%, although this was higher on surgical wards. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- The trust was not meeting the national emergency access target for 95% of patients to be admitted, transferred or discharged within 4 hours. Ambulance handovers over 30 minutes were often delayed and patients often had to wait in the emergency department for admissions.
- Many medical patients were often on outlier wards (a ward that is not specialised in their care). However, this did not happen during the inspection and information demonstrates that these patients were regularly assessed.
- Patient bed moves happened frequently, including at night. Staff were ensuring that patients with lower dependency needs were moved and patients had not expressed concern about their moves.
- The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target and the 62-day referral-to-treatment target, although this had not been met in June 2015.
- The hospital was achieving the 18-week referral-to-treatment time target for medical patients. The target had been met in surgery between April to December 2014 but was not being met between January to March 2015. The target was not being achieved in orthopaedics and ophthalmology.
- The majority of patient who had cancelled surgical procedures for non-clinical reasons were re-booked for surgery within 28 days.
- The trust was meeting national waiting times for diagnostic imaging within six weeks, outpatient appointments within 18 weeks and cancer waiting times for urgent referral appointments within 2 weeks and diagnosis at one month and treatment within two months.
- The trust cancellation rate for appointments was 11%; the England average was 7%. Many of these clinic cancellations were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments.
- Women were able to make choices about where they would like to deliver their babies. They had access early pregnancy assessment and their preferred ante-natal clinics. Women in the early stages of labour had access to telephone support.
- Patient discharge was effectively supported. Patients were regularly reviewed and discharge coordinators worked to improve the discharge of patients with complex care needs. The hospital had problems with increasing delays transfer of care for community services and was working with partners to improve this.
- Support for patients living with dementia was well developed, for example, there was specialist support, appropriate assessment, a sunflower symbol was used and staff had good awareness and training. Support for people with a learning disability needed further development. Although there was support for carers, the hospital needed a flagging system or passport to identify and support patients, and some staff identified the need for further training.
- The trust offers a number of one stop clinics. The breast unit, for example, offers appointments to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by

consultants. Patients who attended the one stop clinics, would see a clinician, have a biopsy taken and see a radiologist if required. If a cancer diagnosis was suspected, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options. This unit provided a responsive service for patients who were anxious in relation to a potential cancer diagnosis.

- Patients having end of life care were identified by a Butterfly symbol so that staff were aware of their needs and those of their family.
- There was a hospital at home service to deliver care to those patients identified as being in the last days or hours of life. The service was 24 hours and seven days a week. Multidisciplinary team working and innovations in electronic records and the use of video conferencing in end of life care also facilitated rapid assessment and access to equipment.
- Patients having end of life care had multi-disciplinary care focused on their physical, mental, emotional and social needs. Patients could have a rapid discharge to home arranged within 24 hours. However, there were delays to the rapid and fast track discharge processes (within 48 hours) and processes were being improved to meet national standards.
- All wards we visited provided care for patients in single sex accommodation bays, in line with Department of Health requirements.
- Complaints were handled appropriately and there was evidence of improvements to services as a result. Some services, however, were not responding to complaints in a timely way.

Are services well-led?

- All services identified the plans to build a new Critical Treatment Hospital as the overall strategy for the trust and there were in-depth plans towards this across services. However, some services did not have specific strategies and plans in the short and medium term to respond to priorities. Some consultants identified concerns with the plans for the new hospital.
- Services had effective clinical governance arrangements to monitor quality, risk and performance. The Outpatients department needed better processes to manage risk and quality.
- Most staff told us overall they had good support from the local clinical leaders and staff engagement was good.
- Many staff identified the visibility and support of the chief executive of trust.
- Joint working between Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital varied. This was important to improve standards, share good practice and develop efficient and effective services across the trust. This was well developed in the emergency department, critical care and end of life care.
- The leadership for end of life care was outstanding. There were robust governance arrangements and an engaged staff culture all of which contributed to driving and improving the delivery of high quality person-centred care. This was an innovative service with a clear vision and supportive leadership and board structure.
- Patient engagement was mainly through survey feedback however, there was some innovation, for example afternoon tea sessions with stroke patients and their families and 'through your eyes' a listening event to surgery.
- The trust had a WOW Award scheme to recognise outstanding service. Staff could be nominated by patients or their colleagues. Recognition through the WOW Awards had led to high levels of staff satisfaction throughout the service
- Ideas to innovative and improve services were encouraged. There was participation in research, quality improvement projects, and innovation in developing new roles for staff, such as the Majors practitioners, volunteers caring in dementia, and advanced critical care practitioners.

We saw several areas of outstanding practice including:

- The trust was developing innovative new roles for staff, for example, majors practitioners in the emergency department and advanced critical care practitioners.

Summary of findings

- Every medical and care of elderly ward had an activity coordinator who planned and conducted different activities for patients after consulting them. The activities included range of things such as arts and craft, music, dance, group lunches and movie time.
- 'Afternoon tea' session was held for patients and their relatives in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education. The session was also attended by a member of stroke association team who delivered educational sessions related to care after stroke. Patients were also given information about support available in the community.
- A nurse led eight bedded day unit in the admissions and discharge lounge for patients who required certain medical interventions: patients were referred to this service by the medical consultants and this service was helping to meet needs of patients who required medical intervention without prolonging their stay in the hospital. Patients were highly complimentary about this service.
- When patients with complex needs on care of elderly wards were discharged to their new home, they were escorted by a member of nursing or therapy staff who spent up to an hour with patients in their new home. This had helped in offering elderly patients with emotional support.
- The early supported discharge team helped stroke patients for up to six weeks following their discharge from the hospital. The staff felt that this gave continuity of care and supported the patients in achieving their goals following the discharge
- Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff.
- Critical care career pathways were developed to promote the development of the nursing team.
- The critical care unit had Innovative grab sheets that detailed the essential equipment to care for each patient in the event the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.
- Pregnant women were able to call Labour Line which was the first of its kind introduced in the country. This service involves midwives being based at the local ambulance operations centre. Women who called 999 could discuss their birth plan, make arrangements for their birth and ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners. Labour Line midwives were able to prioritise ambulances to women in labour if they were considered an emergency. The continuity of care and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they were also awarded second place in the Midwifery Service of the Year Award.
- The breast care unit is a fully integrated multi-disciplinary unit that was pioneering intraoperative radiotherapy for breast cancer at the Royal Hampshire County Hospital.
- The specialist palliative care team provided a comprehensive training programme for all staff involved in delivering end of life care.
- The cardiac palliative care clinic identified and supported those patients with a non-cancer diagnosis who had been recognised as requiring end of life care.
- The use of the butterfly initiative in end of life care promoted dignity and respect for the deceased and their relatives.
- There was strong clinical leadership for the end of life service with an obvious commitment to improving and sustaining care delivery for those patients at the end of their lives.
- All staff throughout the hospital were dedicated to providing compassionate end of life care.

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

Importantly, the trust **must** ensure:

- Patients in the ED are admitted, transferred or discharged within national target times of four hours.
- There is an appropriate system to identify patients with a learning disability.
- Resuscitation equipment is appropriately checked and items are sealed or tagged.

Summary of findings

- Medicines are appropriately managed and stored in surgery
- The early warning score is used consistently in surgery.
- Venous thrombo-embolism assessment occurs on admission for surgical patients.
- Staffing in radiology complies with guidance so that staff do not have heavy workloads and manual handling risks and staff have access to appropriate advice.
- There is effective partnership working so that children and young people with mental health needs (CAMHS) have timely assessment and care reviews.
- Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.
- The outsourced diagnostic imaging service is appropriately monitored and managed to reduce delays.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments, and ensure patients have timely and appropriate follow up.

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

- There is a named lead nurse for children in the ED as per Royal College of Paediatric and Child Health guidelines (2012)
- Staff receive appropriate training and there is a formal process in place for staff to follow to meet requirements of the Duty of Candour.
- Staff maintain Infection control procedures - peripheral cannula care and catheter care and hand hygiene - at all times.
- Nurse staffing levels comply with safer staffing levels guidance.
- Medicines are appropriate managed and stored in maternity and gynaecology.
- Continued action to significantly reduce the incidence of pressure ulcer and falls.
- Equipment in the Maternity unit and outpatients is appropriately checked.
- The level of staff undertaking safeguarding adults and child training needs to meet trust targets.
- The trust target of 80% for mandatory training is met.
- The availability of medical notes for outpatient clinics continues to improve and this should be audited.
- There is a formal method to identify patient's whose condition might deteriorate in the outpatient clinic.
- Clinical audit programmes continue to develop.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Controlled drugs in liquid form are managed and stored appropriately in all the medical wards.
- All staff have a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and mental capacity assessments are always documented or regularly reviewed in patient care records.
- There is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night and several times.
- Review single sex bay arrangements on Victoria Ward to ensure patients privacy and dignity is not compromised.
- Review the need for developing a Critical Care outreach service.
- There is a critical care rehabilitation pathway.
- Paediatric critical care guidelines are reviewed and updated.
- There is a clear process and assurances for critical care staff who have been redeployed elsewhere in the hospital to return to the unit when a patient is admitted to the critical care unit.
- Information for patients is available in accessible formats.
- All DNACPR order forms are consistently completed accurately and in line with trust policy.
- Review the process for 'fast-track' discharge to meet the standards for 90% standard to be discharged with the right level of care within 48 hours if there preferred place of death is home.
- Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed in Maternity and gynaecology.
- There is access to seven day week physiotherapy for children and young people with cystic fibrosis.

Summary of findings

- Complaints are responded to within the trust target of 25 days and there are formal methods to feedback complaints to staff.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	The emergency department (ED) was rated good for providing safe, effective, caring and well-led services. The responsiveness of the service 'required improvement'. The department had a culture of safety where incidents were reported. Learning was shared and changes made as a result of this. The department was visibly clean and hygienic. Medicines were appropriately managed and stored. Staff adherent to infection control procedures, but were working to improve hand hygiene compliance after carrying out their own audits. Equipment was available, fit for purpose and clean. The department had appropriate medical staffing levels that included a consultant present for 16 hours a day. There were a low number of nursing vacancies within the department. Agency staff were seldom used as staff worked flexibly to provide appropriate skill mix and staffing levels. Recruitment for the small number of vacancies was ongoing. Safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place. There were effective procedures to assess and stream patients in the department and escalate patients whose condition might deteriorate. The department provided effective care that followed national guidance and this was delivered to a high standard. Pain relief was offered appropriately and the effectiveness of this was checked. Multi-disciplinary work was in evidence and the department ran its services seven days a week. Patients gave positive comments about the care they received, and the attitude of the staff. Patients and relatives told us they were treated with compassion, dignity and respect. The service had some improvement to make in terms of its responsiveness. The hospital was not meeting the national emergency access target of 95% of patients who required hospital admission to be transferred to a ward or discharged from ED within four hours. Patients were however, assessed

and treated within standard times. Patients were, at times, waiting longer than expected for ambulance handovers and could have long waits in the ED on a trolley. However, risks to these patients were managed. There was good support for patients with a mental health condition and patients living with dementia.
The ED was well led by senior nurses and doctors, and the departmental strategy and vision was recognised by staff. The culture within the department was one of accessible leadership with mutual trust and respect.

Medical care

Good

We found that medical care (including older people's care) was 'good' for safe, effective, caring, responsive and well led.
Process and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents. Themes from incidents were discussed at ward meetings to share learning. The environment was clean and equipment was well maintained. Staff had good access to equipment needed for pressure area care. They were able to order bariatric equipment within 24hours. Infection control practices were followed although needed to improve on some wards. Staff across all services described anticipated risks and how these were dealt with.
Patients whose condition deteriorated were appropriately escalated. The incidence of pressure ulcers and falls was higher than expected. Action was being taken on ensuring harm free care Safeguarding protocols were in place and staff were familiar with these.
Medical staffing, across the medical services, was appropriate and covered medical outliers well. There was a significant shortage of nursing staff on the medical and care of elderly wards. The trust was using bank nurses where shortages were identified. However, we found that safer staffing levels at night were not always met on the care of the elderly ward, Freshfield and Victoria medical ward. The trust was implementing actions to mitigate and reduce the risks.
There were appropriate procedures to provide effective care. Staff provided care to patients based on national guidance, such as National Institute for

Summary of findings

Clinical Excellence (NICE) guidelines. Patient outcomes overall were similar to or better than England average for stroke care, diabetes care and heart attack. Were outcomes were worse than the England average, there was an action plan to address areas where improvements.
Arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. Patients had access to services seven days a week and were cared for by a multidisciplinary team working in a coordinated way. When patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements. However, the capacity assessments were not always documented or regularly reviewed in patient care records.
Staff had received statutory and mandatory training, and described good access to professional development opportunities.
Patients received compassionate care that respected their privacy and dignity. They told us they felt involved in decision making about their care. We found staff were caring and compassionate. Without exception, patients we spoke with praised staff for their empathy, kindness and caring.
Bed occupancy in the trust was below the England average It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. There were no medical outliers at the time of our inspection. Hospital data demonstrated the hospital routinely had medical outliers. Staff told us these patients were regularly assessed and followed by a team of medical consultant and junior doctors. Patient bed moves happened frequently, including at night. Staff were ensuring that patients with lower dependency needs were moved and patients had not expressed concern about their moves.
The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target and the 62-day referral-to-treatment target, although this had not been met in June 2015. The medical services were consistently achieving the 18-week referral-to-treatment time target against a national target 90%.

Summary of findings

Patient discharges were discussed by medical teams daily. Discharge arrangements were supported by discharge coordinators. The hospital had an increasing number of delayed transfers of care to community services. The trust was working with its partners to improve this
Support was available for patients living with dementia and patients with a learning disability. We were given examples of the trust working closely with other local mental health NHS teams to meet the needs of patients in vulnerable circumstances.
The medical service had identified a long-term strategy and priorities around improving the services. There were effective governance arrangements and staff felt supported by service and trust management. Lessons from incidents and complaints were usually shared within the staff.
The culture within medical services was caring and supportive. Staff were actively engaged and innovation and learning was supported. There was good local leadership at ward level. Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy.

Surgery

Good

Surgery services were rated as 'requires improvement' for providing safe care and 'good' for being effective, caring, responsive and well led.
Procedures to ensure safe care required improvement. Resuscitation equipment and the storage of medicines in fridges needed to be appropriately checked in line with trust policy.
Patient risks assessments for potential blood clots had not been done for patients within 48 hours of admission. The early warning score was not consistently being used to identify patients whose condition might deteriorate. There were not always adequate numbers of nursing staff to meet the assessed needs of patients, particularly at night on some wards.
Incidents were reported and appropriately investigated and action plans were developed to improve staff learning and services. Compliance with the Five Steps to Safer Surgical checklist was 94% and there were actions plans to improve this.
Surgical staffing levels were appropriate.
Care and treatment was provided based on national guidelines. The surgical directorate took part in a

Summary of findings

number of local and national audits and outcomes in surgery were similar to or better than the England average. Patients received appropriate pain relief and nutritional support.

There was good multi-disciplinary team working to centre care around patients. Staff had good access to training and received clinical supervision and annual appraisals. Seven day services were developing. Consultant led care was provided with 24 hour cover arrangements. Some multidisciplinary support was available form therapist for colorectal and orthopaedic patients over the weekend.

Patients were consented appropriately and correctly. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The surgical services provided care in a caring and compassionate way. Patients and their relatives told us staff understood their needs and treated them with sensitivity. Patients told us they were involved in their care and treatment and staff provided information in a way they could understand.

The hospital was achieving the referral to treatment time target of 18 weeks in some specialities; the target was not being achieved in orthopaedic and ophthalmology. Most patients who had their surgery cancelled on the day were rebooked for surgery within 28 days. The service was reviewing its capacity to identify ways in which service demands could be better managed

Support was available for patients living with dementia and patients with a learning disability. The service was taking part in a campaign in raising awareness and promoting better care for people living with dementia.

Complaints were handled in line with the trust's policy although many were not dealt with in a timely manner. Information about complaints was not displayed in ward areas

There were good leadership at all a local level. Staff felt supported by the multi-disciplinary team, joint working and strong clinical leadership. Staff felt supported by managers who were considered to be visible, approachable and knowledgeable and were highly respected by their staff.

Summary of findings

There was an effective governance structure to manage risk and quality. Staff were passionate to deliver quality care and an excellent patient experience.
The trust has continued to develop their engagement with patients including initiatives such as 'through your eyes' listening event', which was developed by the division and introduced across the trust. The service took part in research and national projects and innovative practice.

Critical care

Good

We rated critical care services as 'good' for providing safe, effective, responsive and well-led services. The service was outstanding for caring. There were areas of good, outstanding and innovative practice in the critical care services. Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff. To promote the development of the nursing team the senior nursing team and clinical educator had taken the initiative to develop a critical care career pathway for grades 5, 6 and & 7. The nursing team was split into four teams. Each team had a team away day every two months during which they had time allocated to complete mandatory training. In response to difficulties recruiting middle grade (registrar) doctors the unit had developed a two year course in Advanced Critical Care Practice (ACCP), in conjunction with Southampton University. The ward manager's assistant had developed spread sheets that accurately monitored staff annual leave and mandatory training in a timely way and had introduced an automated text system to alert staff of shifts that needed filling. Innovative grab sheets on the unit that detailed required essential equipment needed to care for patients if the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.
There were effective risk management processes in place with processes to ensure learning from incidents was shared across the critical care units at both RHCH and BNHH.

Summary of findings

Staffing levels and qualifications were in line with national guidance. This meant patients received care and treatment from staff who had the necessary specialist skills and experience.
Treatment and care followed current evidence-based guidelines with the exception of outreach services and critical care rehabilitation services. The risk to patients associated with not having these services was being monitored and action was being taken to try to introduce these services. The critical care services participated in national and local audits and there were good outcomes for patients. Staff had effective training, supervision and appraisal and there was good multidisciplinary working to ensure that patients' needs were met.
Data showed that outcomes for patients were comparable with those of similar critical care units.
There was strong leadership of the critical care service across the trust and in the unit at RHCH.
There was a culture of mutual support and respect, with staff willing to help the unit at BNHH when they were short staffed. Innovative ideas and approaches to care were encouraged and supported.

Maternity and gynaecology

Good 

Maternity and gynaecology services were rated 'good' for providing safe, effective, caring, responsive and well led services.
Nursing and midwifery staff were encouraged to report incidents and robust systems were in place to ensure lessons information and learning was disseminated trust wide.
Midwives followed comprehensive risk assessment processes from the initial booking appointment through to post-natal care. Identified risks were recorded and acted upon across both services.
All areas of the service we visited were visibly clean and systems were in place to ensure nurses, midwives and domestic staff adhered to trust infection control policies and procedures.
The gynaecology ward participated in the NHS Safety Thermometer**.** The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The ward conducted monthly audits in respect to patient falls, pressure ulcers, catheters

Summary of findings

and urinary tract infections. However, information about the audits was not displayed. It is considered to be best practice to display the results of the Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed.

Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance.

Policies and guidelines were developed in line with the Royal college of Obstetricians and Gynaecologists (RCOG), Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust for the maternity service to ensure all services worked to the same guidelines. Staff received further training and support in order for them to develop and maintain their competencies. The supervisor to midwife ratio was 1:15.

The funded mid-wife to birth ratio was on average 1:30 which met the trust national and local benchmark. However, there were times during April 2014 to April 2015 when the midwife to birth ratio was 1:32-34. The England average was 1:29. Shortfalls in midwifery staff were due to maternity leave and sickness. Midwives had consistently been able to deliver one to one care in labour and there was no evidence to support harm had occurred to women when there had been a shortfall in midwifery staffing levels. The 103 hours dedicated consultant cover exceeded the recommendation of RCOG, Safer Childbirth (2007).

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

The gynaecological service met the referral to treatment time target for women to be treated within of 18 weeks.

Summary of findings

Translation services were available, and some midwives had undergone further specialist training to support women with additional needs such as learning disabilities and drug and alcohol addictions.
There was vision and strategy for the service which was focussed around plans for the development of a new hospital. Staff and the members of the community had been consulted about the changes to service provision and had been involved in the architectural design of the new building. Short term strategies had been developed to ensure staff were ready for the move to a new hospital and guidelines were embedded across the sites. However there had not been short and medium term plans for the service development.
There were comprehensive risk, quality and governance structures and systems were in place to share information and learning. Staff across the service described an open culture and felt well supported by their managers. Staff continually told us they felt "proud" to work for the trust and that their successes had been acknowledged and praised by the trust board.

Services for children and young people

Good

We rated services for children and young people services as 'good' for providing safe, effective, responsive and well-led services. The service was outstanding for caring.
Incidents were reported and appropriately investigated. Lessons were learnt to support improvements. Staff had an understanding to be open and transparent when things go wrong and the new regulation of Duty of Candour was being followed. Clinical areas were visibly clean and staff were following infection control procedures. Medicines were appropriately managed and stored and equipment was available and regularly tested to be fit for use.
Staff took steps to safeguard children. Children's risks were appropriately assessed and procedures were followed to identified if their condition might deteriorate. Children with mental health problems were, however, not being assessed and supported by mental health professionals in a timely way.

Summary of findings

Action was being taken to ensure safe nurse staffing levels. Consultants were covering middle grade doctor vacancies but this practice was not sustainable in the long term

Care and treatment was based on national guidance and evidence based practice. The services was monitoring clinical standards and participated in local and national audits. The trust scored better than the England average for diabetes and asthma outcomes.

Children and young people had good pain relief, nutrition and hydration. The hospital had received the level 3 “Baby Friendly” Accreditation in the neonatal unit in 23 July 2015 which supports parents to be partners in care.

Staff had appropriate training and were highly competent. Staff worked effectively in multi-disciplinary teams and with external providers to provide a holistic approach to care. The hospital, however, did not have sufficient inpatient paediatric physiotherapists to effectively support patients with cystic fibrosis.

Seven day services had developed for medical staff and consultants were available seven days a week.

Staff were providing a compassionate and caring service. Feedback from people who use the service, those who are close to them, was overwhelmingly positive. Children and their parents spoke of staff going “above and beyond” to provide care and keep them well informed, and of an “excellent” service.

Children and their parents were involved in their care and treatment. Play leaders supported children to understand their care and reduce anxiety.

The service was being planned around managing service demands and responding to the needs and preferences of children, young people and their families. There was good access to the service, with open access for children with chronic conditions and those who had recently been discharged. There were good link with the community child health team, based in the hospital, leading to continuity and an integrated care approach. The service was meeting the needs of children with long-term chronic and life-limiting conditions by working in collaboration with other hospitals and hospices.

Summary of findings

The trust needed to work with its partners to ensure there was a service level agreement for children and young people with mental health needs. There was support for children with a learning disability.
Governance processes appropriately managed quality and risks issues, although we did not see how risks were being escalated to the trust board.
Staff were positive about the local leadership of services and demonstrated they were passionate and committed to delivering high quality, patient focused care.
There was evidence of cross site working, for example, to streamline services and share good practice although it was acknowledged that more work was required to develop consistent service across the trust.
Children and young people were encouraged to feedback ideas to improve the service

End of life care

Outstanding ☆

End of life care at this hospital was "outstanding". We rated it 'good' for safe, effective and responsive services and outstanding for caring and well-led services.
End of life care at this hospital was safe and people were protected from avoidable harm and abuse. Reliable systems and process were in place to ensure the delivery of safe care.
Care and treatment was delivered in line with local and national guidance and there was a clear holistic patient-centred approach.
Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was mostly positive and we observed many examples of outstanding compassionate care.
The leadership for end of life care was strong. There were robust governance arrangements and an engaged staff culture all of which contributed to driving and improving the delivery of high quality person-centred care.
This was an innovative service with a clear vision and a strong focus on patient centred care which was supported by a board structure that believed in the importance of good end of life care for the local population.
There was good multidisciplinary working, staff were appropriately qualified and had good access

to a comprehensive training programme dedicated to end of life care. However we were concerned about the uptake of mandatory training by the specialist palliative care team.
Patient outcomes were routinely monitored and where these were lower than expected comprehensive plans had been put in place to improve. However, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were not always made appropriately and in line with national guidance.
Patient's needs were mostly met through the way end of life care was organised and delivered. However, the rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way. The specialist palliative care team identified rapid discharge as a challenge.
We saw where recommendations and actions to address these audit results had been made and results had been discussed at board level.

Outpatients and diagnostic imaging — **Requires improvement**

We found the outpatients and diagnostic departments at RHCH were outstanding for caring and good for responsive services. The service required improvements to provide safe and well-led services.
Staff were encouraged to report incidents and the learning was shared to improve services. There had, however, been one serious incident requiring investigation of a patient lost to follow up in outpatients where clear actions had not been taken to mitigate future risks. Some of the equipment used in outpatients had not been regularly tested to ensure it was safe to use.
Staff compliance with mandatory training was good in diagnostic imaging but more outpatient staff needed to complete mandatory training.
Radiographers worked alone overnight and was responsible for covering all plain film X-rays for the main hospital and the emergency department as well as basic computerised tomography (CT) scans. Radiographers reported a heavy workload and raised manual handling issues. Between 10.00pm and 8am, radiology was supported by an overnight

outsourced radiologist service. Staff identified delays in the process to authorise request and provide advice on imaging which meant delays in the patient diagnosis.
In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission.
The environments were visibly clean and staff followed infection control procedures. Medicines were appropriately managed and stored. Patients were assessed although, Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used. Patients were assessed and observations were performed, where appropriate. However, there was not a tool in use to identify patient's whose condition might deteriorate. In interventional radiology there was evidence of the WHO checklist being completed and patient protocols in place
Nurse staffing levels were appropriate as there were few vacancies. There was an ongoing recruitment plan for nurses and radiographers.
There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in rheumatology and ophthalmology. However, there was not a local audit programme to monitor clinical standards. Staff had access to training and had annual supervision but did not have formal clinical supervision.
Staff followed consent procedures but did not have an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.
Staff provided outstandingly good, compassionate care, and ensured patients and relatives were well-supported whilst in the department. We were informed of some exceptional compassionate care for patients, with nurses and radiography staff going the extra mile and far above and beyond of that expected. Patients were well-informed and routinely involved in the planning of their care and treatment. Staff recognised when a patient required extra support to be able to be included in

understanding their treatment plans. The feedback from patients and relatives we spoke with was overwhelmingly positive, within very detailed conversations.

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

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

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

Governance processes required further development in the outpatient and diagnostic department to monitor risks and quality.

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Nursing staff did not identify a strong leadership presence in the

Summary of findings

outpatient department and did not feel well supported. Radiographers felt well supported by their immediate line managers. They told us that they felt well supported and valued. Staff said they enjoyed working for the trust due to the strong team support from colleagues.
There were however, few examples of local innovation and improvement to services. In diagnostic imaging, a staff representative role was being introduced following to support and implement positive changes within the department that staff members themselves had recommended. Public and patient engagement occurred through feedback such as surveys and comment cards.

Royal Hampshire County Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Royal Hampshire County Hospital

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

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

The first Hampshire County Hospital was founded in the centre of Winchester in 1736. It moved to another city centre site in 1759 and stayed there for more than a century. It moved to its present site in Romsey Road in 1868, with support and advice from Florence Nightingale, and was granted its Royal prefix by Queen Victoria.Royal Hampshire County Hospital (RHCH) is one of the acute district hospitals, and is based in the city of Winchester, Hampshire. The hospital has approximately 457 beds, and they had 44,273 emergency attendances in ED, and 211,418 outpatient attendances last year.

The RHCH provides a full range of general hospital services including accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, out-patient clinics and paediatric care.

The site also houses Florence Portal House (which provides maternity, neonatal, breast screening and some gynaecology services) and an education centre. RHCH runs an Outpatient Department from Monday till Friday located on Level B of Burrell Wing

The RHCH employs approximately 654 clinical staff. They do not outsource for any contracted staff, and non-clinical staff are employed in all of the support functions such as portering, facilities management and catering provision.

We undertook this inspection of Hampshire Hospitals NHS Foundation Trust as part of our comprehensive inspection programme. The trust was in priority band 6 according to our Intelligent Monitoring system (with band 1 being the highest risk and band 6 being the lowest risk).

The inspection of RHCH took place on 28 to 31 July 2015. The full inspection team included CQC senior managers, county managers, inspectors and analysts. Doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers also joined this team.

Detailed findings

We reviewed the following core services provided at RHCH: urgent and emergency care, medical (including older people's) care, surgery, critical care, maternity and gynaecology services, children and young person's services, end of life care, and outpatient and diagnostic services.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

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

How we carried out this inspection

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

We carried out an announced inspection visit to the Royal Hampshire County Hospital on 29 and 31 July 2015.

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

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

We conducted focus groups and spoke with a range of staff in the hospital, including nurses, matrons, junior doctors, consultants, governors, administrative and clerical staff, porters, maintenance, catering, domestic, allied healthcare professionals and pharmacists. We also interviewed local 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 Royal Hampshire County Hospital.

Detailed findings

Facts and data about Royal Hampshire County Hospital

The Royal Hampshire County Hospital (RHCH),Winchester: key facts and figures

RHCH is the acute district general hospital provided by Hampshire Hospitals NHS Foundation Trust, within the city of Winchester.

1. Context: RHCH

- Context: RHCH has around 457 beds providing the following leading specialties: Trauma & Orthopaedics; Critical Care Medicine; Medical Oncology; General Surgery; Colorectal Surgery; Ophthalmology; Cardiology; Rehabilitation; Accident & Emergency; Geriatric Medicine; General Medicine; Geriatric Medicine; Rheumatology; Respiratory Medicine; Gastroenterology; Stroke Medicine; Paediatrics; Community Paediatrics; Obstetrics; Gynaecology.
- 44,273 A&E attendances (April 2015 - March 2015)
- 211.418 outpatient appointments (May 2014 – April 2015)
- The number of staff, approx. 645 clinical staff.

2. Activity: Trust wide

- Inpatient admissions: 115,011 (2014/15).
- Outpatient attendances: 547,719 (2014/15) of which 23% were first attendances and 50% were follow up
- A&E attendances: 116, 283 (/2014 /15).
- Births: 3,073 (2014/15).
- Deaths: 1,533 (2014 /15).

3. Bed occupancy: Trust wide

- General and acute:

Q1 2014/2015: 72.6%;Q2 2014/2015: 81.7%;Q3 2014/2015: 81.7%

This was lower than 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 33.3% bed occupancy (April 2014 to December 2014) lower than the England average of 57.9%.
- Adult critical care was approx. 95% – above the England average of 87.6% (May 13 – Nov 14).

4. Intelligent Monitoring:

- The priority banding for inspection for this trust was 6, and their percentage risk score was 1.56%. (1 = highest risk; 6 = lowest risk)
- In the latest Intelligent Monitoring report (May 2015), this trust had four risks and no elevated risks. The risks identified were as follows:
- SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (Effective domain);
- Monitor – Continuity of service rating (Well-led domain);
- Composite of PLACE indicators (Cross-cutting).
- PLACE score for food.

5. Safe: Trust wide

- 'Never events' in past year: 0 (2014/15).
- Serious incidents: 91 (2014/15) - 40 at RHCH.
- National Reporting and Learning System (February 2014 – January 2015): 6,544 events reported

England average

Deaths

0.3%

0.1%

Severe harm

0.6%

0.4%

Moderate harm

6.8%

4.0%

Low harm

29.6%

21.8%

No harm

62.7%

73.7%

- There were 74 cases of C Diff in this trust between April 2013 and March 2015 (average of 37 per year), and five cases of MRSA (2.5 per year).
- Data from the Patient Safety Thermometer showed that there were 42 falls, 521 pressure ulcers, and 188 cases of Cather Urinary tract infections (March 2014 - March 2015).

Infection control (April 2013- March 2015)

- 74 cases of Clostridium difficile (average 37 per year) – no evidence of risk.
- Five cases of MRSA (2.5 per year) – no evidence of risk.

Waiting times

- A&E – Time to initial assessment: below England average and 15 minute standard (2014/15)
- A&E - Time to treatment: below England average and 60 minute standard (2014/15)

6. Effective: Trust wide

- All mortality indicators for the trust are in line with other non-specialist trusts.

7. Caring: Trust wide

- CQC Inpatient Survey (10 areas): similar to other trusts.
- Friends and Family Test inpatient: Significantly above the England Average (March 2014 – February 2015).
- Friends and Family Test A&E: above the England Average (March 2014 – December 2014); Similar to the England average (September 2014, January 2014 to February 2015)
- Cancer Patient Experience Survey (34 questions): similar to other trusts for 33 questions; and highest scoring 20% for one question (2012/13 - 2013/14)
- Patient-Led Assessments of the Care Environment - below England Average: cleanliness, food, privacy, dignity and wellbeing and facilities.

8. Responsive: Trust wide

- Between April 2014 and March 2015, this trust received 606 complaints (255 at RHCH). Average number of working days to close a complaint: 36 days.
- A&E four-hour standard – not met; below the England average and 95% target (April 2013 to December 2014).
- For the incomplete pathway, the Referral to treatment time target (92%) of patients on a waiting list for less than 18 weeks). The overall performance was 90.3% (RHCH) - March 2015.
- 96.7% of cancer patients were seen by a specialist within two weeks of an urgent GP referral (2014/15 Q4), which is above the operational standard of 93 %.
- The proportion of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was 98.9% (2014/15 Q4, standard of 96%). 87.5% of cancer patients waited less than 62 days from urgent GP referral to first definitive treatment, which is above the standard of 85% (2014/15 Q4).
- Delayed transfers of care: 38.8% of those patients with a delayed transfer of care were awaiting Nursing Home Placement or Availability: that was above the England average of 12.4%.

9. Well- Led: Trust wide

- NHS Staff Survey (2014): This trust performed in the top 20% of trusts for three key findings, and in the bottom 20% of trusts for two key findings. For the remaining 24 key findings analysed, the trust had a similar performance to other trusts. The response rate in this trust was 45% (higher than the median rate across all trusts of 43%).
- Staff Sickness rate was 3.71% - below the England average (February 2015)
- Use of bank and agency staff – below the England average.
- General Medical Council National Training Scheme Survey (2015): The trust was within expectations for all areas of the National Training Scheme Survey.

10. CQC Inspection History - RHCH:

- There have been 3 inspections at RHCH since 2011.
- 7 outcomes were inspected, and the hospital was compliant with 5 of these. The non-compliant Outcome 4 and 13 were met in January 2014

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	☆ Outstanding	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Requires improvement	Not rated	☆ Outstanding	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) of the Royal Hampshire County Hospital (RHCH) serves the towns of Winchester, Eastleigh and surrounding villages. It provides a service 24 hours a day, seven days a week. This ED provides specialist care for patient with stroke and is the receiving unit for these patients. It does not provide specialist major trauma support as there is a major trauma centre at Southampton General Hospital.

The department was purpose built and consists of a waiting room for walk in patients, with a reception area. There is a triage room off of the main waiting area as well as a separate waiting room for children. There are four minors cubicles and a four bedded short stay ward. The majors area has access for ambulances to a three bedded resuscitation room. The majors area within the department has six bays as well as a cubicle that is used for the initial assessment of patients brought in by ambulance.

The adult emergency departments of Hampshire Hospitals NHS Foundation Trust last year saw 116,280 patients. This figure includes 20% of patients who were under the age of 16 years attending the RHCH department. Within the department there was a short stay unit where patients could be monitored overnight if required.

During this inspection we visited all areas within the emergency department. We spoke with 16 patients and 21 members of staff. We reviewed seven sets of patients' records. We observed interactions between patients and staff, considered the environment and looked at care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Urgent and emergency services

Summary of findings

The emergency department (ED) was rated good for providing safe, effective, caring and well-led services. The responsiveness of the service 'required improvement'.

The department had a culture of safety where incidents were reported. Learning was shared and changes made as a result of this. The department was visibly clean and hygienic. Medicines were appropriately managed and stored. Staff adherent to infection control procedures, but were working to improve hand hygiene compliance after carrying out their own audits. Equipment was available, fit for purpose and clean.

The department had appropriate medical staffing levels that included a consultant present for 16 hours a day. There were a low number of nursing vacancies within the department. Agency staff were seldom used as staff worked flexibly to provide appropriate skill mix and staffing levels. Recruitment for the small number of vacancies was ongoing. Safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place. There were effective procedures to assess and stream patients in the department and escalate patients whose condition might deteriorate.

The department provided effective care that followed national guidance and this was delivered to a high standard. Pain relief was offered appropriately and the effectiveness of this was checked. Multi-disciplinary work was in evidence and the department ran its services seven days a week. Patients gave positive comments about the care they received, and the attitude of the staff. Patients and relatives told us they were treated with compassion, dignity and respect.

The service had some improvement to make in terms of its responsiveness. The hospital was not meeting the national emergency access target of 95% of patients who required hospital admission to be transferred to a ward or discharged from ED within four hours. Patients were however, assessed and treated within standard times. Patients were, at times, waiting longer than expected for ambulance handovers and could have long waits in the ED on a trolley. However, risks to these patients were managed. There was good support for patients with a mental health condition and patients living with dementia.

The ED was well led by senior nurses and doctors, and the departmental strategy and vision was recognised by staff. The culture within the department was one of accessible leadership with mutual trust and respect.

Urgent and emergency services

Are urgent and emergency services safe?

Good

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

We rated safe as 'good'.

The department had a culture of safety, incidents were reported and action was taken in response. Learning was shared between Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital. Infection control procedures across the department were being followed and action was being taken on specific areas to improve compliance with standards. Medicines were managed and stored safely and equipment was available and regular checked to ensure it was safe to use.

The requirements for safeguarding children, young people and vulnerable adults were understood by staff. Specific training in child protection was provided, although the take up was less than the trusts 80% target, with 72% of nurses and 40% of doctors participating.

There were effective procedures to assess and stream patients in the department and escalate patients whose condition might deteriorate. The department often had instances where patients' brought in by ambulance had to wait on trolleys. However this potential risk to patients had been addressed with the use of specific staff to take handovers from ambulance crews. These staff also provided care and observation for the waiting patients until they could be moved into the department.

The department had appropriate medical staffing levels, with consultants present in the department for 16 hours a day.

There was appropriate nurse staffing levels, and a low number of vacancies. There was not a lead children's nurse or children's nurses working in the department. There was however, a link arrangements with a named nurse for children and a consultant lead for children working in the department.

Incidents

- Medical, nursing and support staff were aware of their responsibilities in reporting incidents and we saw examples which had been submitted. Staff understood the value of reporting "near misses" and told us that this happened.
- Incidents and accidents were reported using a trust wide electronic system: all staff had access to this and knew which incidents required reporting.
- There were various systems to ensure that learning from incidents was shared throughout the division. Staff told us that there were governance and staff meetings which shared learning from incidents. There was a monthly newsletter produced by the medical team which was shared across the departments, staff said that this was useful. The department also used 'Top 10 Tips' which was based on feedback from incidents and this was discussed at handovers.
- Staff were aware of the requirements of Duty of Candour when giving feedback about incidents to patients and relatives.
- Mortality and morbidity meetings were attended by doctors and nurses to ensure that any learning was shared. Consultants' worked half their time across both EDs' in the trust at the Royal Hampshire County Hospital and the Basingstoke and North Hampshire Hospital. This ensured that learning from incidents was communicated and shared across the departments.

Cleanliness, infection control and hygiene

- The department was visibly clean. There were hand sanitising gels in use at the main doors to the department. We observed that these were being used by people entering the department.
- There were sufficient facilities for hand washing. During our inspection a hand washing sink became blocked, this was reported by staff and rectified by the facilities team within an hour of being reported.
- The department displayed posters indicating the "key moments for hand hygiene": this initiative was aimed at ensuring that all staff clean their hands after patient contact. This standard was audited on a monthly basis. The results (January – March 2015) showed overall 90% of staff were compliant with the standard. Staff that were not compliant were spoken to about the missed opportunities to clean their hands.

- Staff complied with the 'bare below the elbows' policy in clinical areas. Gloves and aprons were available for staff when they needed them.
- Monthly audits to ensure the cleanliness of facilities and all equipment were also carried out.
- Central venous access devices (these are tubes inserted into a main vein in the arm or neck that are used to administer medicines or monitor a patient's condition) were recorded and checked three times per day. A form recording the details insertion of the device was also completed, but audits showed that this sometimes did not happen. The results of the audits were shared with staff who had been reminded where the documentation is kept in order to remind them to complete it.
- Patients that had a cannula (a tube into a vein to allow fluid of medicines to be given) were also audited to ensure they were checked three times a day. The audits showed that this was not always happening and a message had been published in the newsletter. Spot checks on this standard were implemented to increase compliance.
- Patients with a urinary catheter (or that had one inserted while in the department) were also audited to ensure correct documentation was completed. Audits showed that care plans were not always completed and action was being taken.
- Chemicals required for cleaning a blood spill (or other body fluid) were stored appropriately.
- There were no reported incidences of MRSA or Clostridium difficile in the department. Patients admitted with a suspected gastrointestinal infection were isolated from other patients and infection control precautions were taken.

Environment and equipment

- There was a receptionist located at the desk, who had a good view of the waiting room. In the event of an incident there was no "panic button" which made some reception staff anxious. However, help could be hailed as there was an open access into the main department from behind the desk. A receptionist was on duty 24 hours a day.
- A triage room led directly off the waiting room, where patients with minor injuries could have an initial assessment by a triage nurse or emergency nurse practitioner (ENP).
- There was a small relative's room for use when patients were admitted by ambulance directly into the majors' area of the department or the resuscitation room.
- The resuscitation room was divided into three bays, one of which was equipped for babies and children. Resuscitation equipment was checked daily against a checklist. We observed that this was checked and signed by staff every day.
- There were appropriate waste management processes in place that ensured segregation and secure disposal. Mobile bins for the disposal of sharps (needles and other sharp medical devices) were available for use in the resuscitation room.
- The department was tidy and fit for purpose, with equipment maintained in good order. Electrical devices had been tested.
- There was good access to x-ray and the CT scanner, as both facilities were located just outside the department. The plaster room was conveniently located.

Medicines

- The storage of medicines within the department was appropriate and safe. This included the storage of controlled drugs (CDs). These were checked regularly and reconciled against stock levels. Drugs used in emergencies were checked daily (such as those in the resuscitation room).
- Medicines were stored correctly in the department, including medicines that were used to transfer critically ill patients around the hospital. Medicines and intravenous fluids were stored in locked cupboards.
- Refrigerators for temperature controlled storage of medicines were kept locked and the temperatures were checked. However, refrigerator temperatures were not always recorded daily as specified on the check sheet.
- The department used patient group directions (to allow some medicines to be given without a prescription). These were found to be in-date and accessible for staff to use.

Records

- Records for patients attending the ED were paper based during their stay in the department. These paper records were scanned onto the computer system to allow good access to the records of patients who have

attended the department before. Paper records were disposed of using an outside contractor providing secure shredding to ensure patients information was kept safe.
- Access to electronic records was protected by passwords, and data was backed up safely.
- The records we reviewed during our inspection included pain scores and the use of the early warning system. Records of children included consideration of safeguarding checks.
- Records also included risk assessments for pressure ulcers, falls and infection control. Nursing staff also completed a check list to assist them to identify patients who were vulnerable or at risk of mental health problems. Observations and transfer plans were also recorded.
- Patients' in the Majors area had their national early warning scores (NEWS) recorded in their record. The patients' NEWS was also displayed on a whiteboard and included details of when their physical observations needed to be repeated. Patients were only referred to by cubicle number to protect their identity.

Safeguarding

- The requirement for staff to participate in mandatory training for safeguarding children was identified as a risk on the department's risk register, due to poor uptake.
- There was a safeguarding policy and procedure in place and this was understood by staff.
- The Joint Children's Protection Register (a system for checking if children have been at risk of abuse) was available for checking within the department. The receptionists were observed checking the register when booking in two children. Receptionists knew how to escalate any concerns they had if the system flagged any child attending the department.
- Adult safeguarding training had been completed by 76% of nursing staff, this was below the trust target of 80%. 40% of medical staff had completed this training. The participation of staff in safeguarding training had been identified as a risk by the department.
- Children's safeguarding mandatory training had been completed by 72% of nursing and 40% of medical staff.
- In the minor treatment area of the department there was a pathway on display to assist staff in the management of suspected domestic violence

Mandatory training

- The trust submitted data about staff attendance at mandatory training. This indicated that records were kept of training, and training opportunities were available for staff.
- Participation in mandatory training was below the trust's target of 80%. The infection control training was attended by 20% of doctors and 65% of nurses; Manual handling training by 60% of doctors and 77% of nurses; Information governance (IG) training by 80% of doctors and 89% of nurse (the trust's target for IG training was 95%)
- The trust data on mandatory training showed that attendance on other training modules such as, conflict resolution, health and safety and fire was less than the 80% target.

Assessing and responding to patient risk

- The Manchester Triage System was in use in the accident an emergency department for adults, children and young people. This tool determines the priority of patients treatments based on the severity of their condition and is widely used in the UK.
- Data provided by the trust (February 2014 – January 2015) showed that the trust performed better than the national average with an immediate initial assessment. The trust median time to initial assessment was 2-3 minutes, compared to the England average of 4-6 minutes, and the national standard of 15 minutes. The trust time to treatment was better than the England average since October 2013.
- Patients who were critically ill or required resuscitation were brought by the ambulance crew directly into the resuscitation room. This facility was appropriately equipped for the resuscitation of adults, children and babies. The ambulance service would phone to ahead to allow the department to prepare to receive such a patient if the situation allowed. A kit of equipment and medicines was available to support clinical staff in transferring critically ill patients around the hospital. There was an appropriate store of controlled drugs located in the resuscitation room.
- There was a member of staff allocated to care for patients in the resuscitation room.

- Patients who had suffered a stroke would be taken to the Royal Hampshire County Hospital as this was the designated receiving unit for the specialist treatment of stroke. Patients with chest pain were taken to Basingstoke and North Hampshire Hospital for specialist treatment if possible. The use of specialist services such as this has been shown to reduce the number of deaths from these medical conditions.
- Staff monitoring a patient's condition used the National Early Warning Score (NEWS) to ensure that deterioration was detected and escalated appropriately. For children the Paediatric Early Warning Score (PEWS) was used.
- In the event of a critically ill child attending the department there were processes in place for immediate referral to a paediatrician. There was a protocol in place that critically ill children requiring transfer to a specialist facility elsewhere would be collected directly from the hospital by the Southampton and Oxford retrieval team (SORT). The SORT team would provide specialist staff to support the child during the transfer.
- There were four cubicles in the minors' area that was managed by emergency nurse practitioners (ENPs) who offered a service between 7.30am and midnight. This service was in the process of being extended to ensure quick treatment times for walk in patients.
- There was a four bedded short stay ward for patients who required recovery from a procedure or monitoring. The short stay ward had two cubicles that were both ensuite. These could be used for end of life care if required.
- The majors' area had six bays and an extra bay for observation and assessment by the hospital ambulance liaison officers (HALO). These staff were paramedics that were employed by the trust. The HALO's role is to take handover from ambulance staff and perform initial assessment in order to improve flow and speed up initial assessment.
- Patient flow issues meant that corridors were sometimes used to accommodate patients on trolleys who were awaiting treatment. Staff understood the potential risks posed by this, and ensured that patients were moved as soon as possible depending on their clinical needs. The HALOs provided care, support and observation for patients waiting on trolleys. There was a room which could be used for observation and assessment by the HALOs. This could also be used to provide privacy if a waiting patient needed to use the toilet.

Nursing staffing

- Staffing numbers were identified based on the acuity tool used by the trust. Shifts were agreed in advance against the planned registered nurse to patient ratios required for each shift and these were rated Red Amber or Green (RAG) in terms of staff numbers. Any shifts that could not be adequately staffed on the rota were escalated and reported on. In June 2015, the majority of early/long and night shifts were staffed as planned (higher than minimum staffing levels) or were lower than planned but above minimum staffing levels. The majority of late shifts were staffed at minimum staffing levels. There were no red shifts where the nurse staffing level is deemed unsafe. This had been the pattern from January to June 2015.
- Actually staffing was similar to the predicted RAG rating. The department at RHCH had a low vacancy rate for nursing staff. Staffing rotas in June and July 2015, demonstrated that the department was able to cover a shortfall in staffing with its own nurses. There was minimal use of agency nurses across the department.
- The unit had a number of ENPs who were managed and supervised separately from the departments nursing staff. The ENPs' led the minor injuries service and provided a 'see and treat' service.
- The NEWS tool was used to decide on the acuity of patients, and helped decide where they needed to be cared for within the department.
- Handovers for nursing staff were conducted in front of centrally located white board by the nurse in charge. During handovers patients were identified by cubicle number to protect their identities and maintain their confidentiality.
- There was no specific handover tool in use, however this was on the risk register. A tool was being considered to be adapted for use in the department; no date was given for completion of this.
- In addition there were departmental consultant led reviews attended by the nurse in charge, junior doctors and ENPs.

- There were no trained children's' nurses employed in the department but there was a link nurse available for advice. The Royal College of Paediatrics and Child Health recommendations (2012) state that there should be a lead children's nurse for the emergency setting.
- There were staff that maintained the department's supplies and housekeeping staff. There were plans for a general assistant post to be developed in the department to carry out duties such as delivering patients food, assistance with portering and housekeeping duties.

Medical staffing

- There were 17.5 consultants and they divided their time between the Royal Hampshire County Hospital and the Basingstoke and North Hampshire Hospital departments. There was sufficient consultant cover. One consultant had been appointed as the lead for children as they have specialist training in this area.
- The consultant rota is divided into two shifts covering 8am-6pm and 1pm-9pm. The consultants we spoke to told us they spend 8-10 hours in the department at weekends. The consultant cover provided was therefore compliant with the recommendation from the College of Emergency Medicine of 16 hours per day.
- Middle grade doctors were in the department 24 hours per day. There were lower than average number of middle grade doctors employed by the trust (25%), the average for England (39%). Middle grade doctors we spoke to told us that they were not able to access education and training due to working commitments.
- Departmental consultant led reviews occurred daily at 8am, 1pm and 5pm and were attended by the nurse in charge, junior doctors and ENPs. The purpose of these handovers was to ensure everyone had an overview of how the department was running. Additionally information from these meetings would inform the bed meeting which looked at capacity across the hospitals.
- There was no specific handover tool used, this was identified as a risk on the departments risk register. A suitable tool was being adapted for use in the department, it was not clear when this was to be implemented.
- The department had four trainee majors' practitioners (MAPs) to support critically ill patients in the majors' area. This development was in the early stages. The MAPs worked across this hospital at Basingstoke and North Hampshire Hospital.

Major incident awareness and training

- There was a major incident plan for the ED. Staff were given training on how this plan would be implemented by Majors practitioners (MAPS).The major incident policy was last reviewed in May 2013.
- Materials and supplies for dealing with hazardous materials that may be required in the event of an incident were available and stored securely in a container outside the department.
- Security for the department was good, staff used electronic pass cards to gain access to the clinical area. There was CCTV in use 24 hours a day and this was continually recorded. There was a security guard on site who told us that all security staff were trained in de-escalation and restraint techniques. Security were rarely called to ED for this purpose.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

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

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

We rated effective as good.

National guidelines and best practice were being used to provide evidence-based care and treatment. There were care pathways in place for sepsis, stoke and fractured neck of femur. Patient outcomes and the results of national audits were within the expected ranges. Pain relief was offered to patients in a timely way and its effectiveness monitored. Patients were offered food and drink.

Staff were competent and had undertaken appropriate specialist training. Multidisciplinary working was evident ensuring the patient was at the centre of their care.

Staff had a good understanding of consent and the Mental Capacity Act, however, staff were less familiar with Deprivation of Liberty Safeguards (DoLS)

Evidence-based care and treatment

- Policies based on National Institute of Health and Clinical Excellence (NICE) and College of Emergency Medicine guidelines were in use in the department, some were accessed via the intranet. Posters were displayed in discreet clinical areas to highlight changes to clinical guidance and to raise awareness.
- A range of clinical care pathways was used that aligned with national guidelines.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines.
- The hospital was the designated receiving unit for patients with stroke as the hospital could provide specialist treatment.
- The 'Sepsis Six' had been implemented across the department, to prioritise timely diagnosis of patients admitted with infections. Early treatment of sepsis reduces complications and improves outcomes for patients. The sepsis pathway was on display in the majors' area.
- Staff had access to databases that provided information on poisonous substances.
- They also access to local policies and procedures.
- There was a working clinical audit programme and evidence of learning and improvement as a result. Information was shared across the trust sites. An example was an audit of patients presenting to ED with kidney stones. This was aimed at increasing diagnosis using CT imaging and to reduce the risk of kidney damage. This initiative had prevented patients with kidney stones being admitted to hospital when the admission was not necessary.

Pain relief

- Pain scores were used as part of the normal observations to record patients' pain and to ensure that medicines for pain were effective. Pain scoring tools specifically designed for children were also in use.
- Records demonstrated that pain was assessed as part of the initial triage to allow early access to pain relief for patients.
- Patient group directions were in use to enable pain relief medicines to be administered by nursing staff without a prescription.

Nutrition and hydration

- Patients who were assessed as able to eat and had been in the department over a meal time were offered food and drinks. Relatives attending with critically ill patients were also offered refreshments.
- There was a vending machine for snacks located in the waiting area, and water was available.

Patient outcomes

- The department took part in national audit schemes such as the College of Emergency Medicine (CEM) audit for the measurement of vital signs and repeat checks during the attendance at ED. Junior doctors were encouraged to participate in these audits. Data from the 2013-14 CEM audit showed mixed results in the Asthma in children audit with partial compliance to the standards. In the Paracetamol overdose audit one of the five standards was met by the department. The severe sepsis audit met the majority of the standards.
- The department had implemented a range of measures to ensure that patients who had infections were screened for sepsis and treated quickly. The clinical audit of sepsis was completed at the Basingstoke and North Hampshire Hospital site. The results of this were shared across the two departments. The audit had not yet been done at RHCH.
- The computer system ensured that patients' with certain potentially serious conditions were seen by a consultant before being discharged.
- The unplanned re-attendance rate did not meet the national standard in the period April 2013 and January 2015. However the performance was better than the England average over this period.

Competent staff

- The trust data on appraisal rates in ED showed that less than 50% of nursing staff below band 7 had an appraisal last year. Appraisal rates for medical staff in ED were higher for senior doctors (78%) but below 50% for junior doctors.

- The department employed a senior nurse (Band 7) to facilitate education programmes and assist staff with education and training. The facilitator was responsible for carrying out learning needs analysis for the staff across the department to ensure that staff were up to date with training. A package of training called 'Essentials of Emergency Care' had been developed by the facilitator. Nursing staff completed a competency based training folder to compliment practice based learning.
- The department provided nurses with booklets to record mandatory training. If other training was undertaken this may be required to be done in the member of staffs own time.
- Junior doctors told us that there was not a specific departmental induction for each of the two sites they worked at. The General Medical Council national survey (2015) data for junior doctors reports that the adequacy of induction processes was in the lower quartile of results.

Multidisciplinary working

- There was effective multidisciplinary working within the ED. We observed positive team relationships between doctors, nurses and other staff, this was a notable feature of this department.
- Staff reported good working relationships with specialist teams who were called to review patients in the department.
- Although the department did not have any trained children's nurses there was a link nurse for children and a lead consultant for the care of children who were available as a resource. The children's ward at the hospital was responsive to calls for assistance from the emergency department.
- The emergency department had access to a therapy service to facilitate discharge for patients with complex needs. This service runs weekdays between 8.30am and 6pm. Staff told us that this service is effective in getting patients with complex needs home. The service was run by another local Trust.
- There was a GP out-of-hours service provided by another local trust that was located near the department. Some patients attending the emergency department were seen by this service if they attend with a minor illness.
- The alcohol and substance misuse liaison team were based at Basingstoke and North Hampshire hospital. They supported the department as needed, but not out-of-hours.
- Access to mental health assessment was through a local Trust who had staff on an adjacent unit on the hospital campus.

Seven-day services

- The department was in operation seven days a week, 24 hours per day.
- Emergency nurse practitioners provided a nurse led treatment service between 7.30am and 12pm every day
- The emergency department used the plaster technicians to apply complex casts to support fractured bones. This service was available Monday to Friday between 8am and 5pm. Outside of these hours emergency department staff provided this service. There was access to pathology across 24 hours to analyse patient's blood samples.
- There was access to diagnostic tests within the department, as well as x-rays and CT scans across 24 hours.
- There was access across 24 hours to x-ray and CT scans. Reporting on x-rays and scans was done out of normal hours by an external provider. Although there had been some feedback about delays in getting x-ray and CT scan reports back, a senior doctor told us that this service had reduced delays to diagnosis overall.

Access to information

- The Joint Children's Protection Register (a system for checking if children have been at risk of abuse) was available for checking within the department. This system allowed any other agencies involved in the protection of the child to be notified if they attended the emergency department.
- All paper patient records generated during an episode of care were scanned onto an electronic record when the patient was discharged or transferred out of the

department. A secure shredding service was used to ensure patient information was kept safe. This also meant that there was immediate access to records for any patients re-attending ED.
- Access to all electronic records was protected with passwords.
- Discharge summaries were completed for patients efficiently within 48 hours, and these were sent to GPs by post. However, doctors told us that sending by post meant that GPs did not always get these summaries before seeing the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed nurses and doctors asking patient's consent before carrying out observations and examinations.
- We did not see anyone who required a Mental Capacity Act assessment during inspection to judge their quality and were only able to ask staff about this.
- Staff received assistance from Southern Health staff in regards to the assessment of mental capacity to consent to treatment. Staff acknowledged that there was insufficient training in the assessment of capacity with patients with a learning disability. We found no evidence of a plan to address this.
- Staff had an awareness of the requirements around and the Mental Capacity Act, but were less secure in their knowledge around Deprivation of Liberty Safeguards.

Are urgent and emergency services caring?

Good

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

We rated caring as good.

Staff provided compassionate care and ensured that patients were treated with dignity and respect despite the challenges of the department. The comments from patients were positive about the care and treatment they had received. The staff were motivated and engaged and put patients first. Patients told us that they were given information and felt involved in decision making. We observed that patient's privacy and dignity were maintained at all times.

The results of the NHS Friends and Family Test (FFT) showed that a higher than average number of patients would recommend the department. The response rate for the FFT was also greater than the England average. Emotional support was given to patients and their families. The A&E survey results for caring were similar to other trusts in England.

Compassionate care

- The reception desk was open and welcoming and had recently been modified. However, from the waiting room seating it was possible to hear a patient giving their personal information to the receptionist.
- The trust was rated as similar to other trusts' in England on the question of being overheard in the waiting room, in the A&E survey data for 2014.
- We observed nurses and doctors providing care in the department. Staff demonstrated respect for the individual's personal, cultural and social needs of patients. Staff spoke to patients in a respectful and considerate manner. Consent was sought from patients before undertaking treatment, observation or examinations.
- We observed that dignity and respect for patients was maintained at all times during treatment or examination.
- Staff responded promptly to the needs of patient's in the department.
- The NHS Friends and Family test results showed that between 86%-97% (results March 2014-February 2015) of patients' would recommend the department. The response rate to the survey is higher than the England average.
- The A&E survey results showed that the ED questions related to caring were similar to other trusts in England.

Understanding and involvement of patients and those close to them

- Most relatives and patients we spoke to were very happy with the service, as they were kept informed and

assessed promptly. One patient we spoke to told us that the he felt the service had improved, he had been seen quickly and commented that the staff attitude was better than in his previous experience.
- The department was not busy when we inspected, and the patients attending were happy with the care and treatment they received. Relatives commented that staff were caring and maintained the patient's privacy and dignity during assessment and treatment.
- There was a relative's room inside the majors' area entrance which was used to accommodate relatives of critically ill patients in the resuscitation room. Staff told us that relatives using this room were regularly updated on the condition of the patient.

Emotional support

- The bereavement team were very responsive and able to provide support for relatives.
- There were chaplaincy services available for patients or relatives who needed them. This included access to emotional support through periods of distress.

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

Requires improvement

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

We rated responsive as 'requires improvement'.

The demand on the service was high and the flow of patients was sometime restricted by capacity issues within the hospital. This sometimes resulted in patients waiting on trolleys. The trust has failed to meet the national standard that requires 95% of patients to be admitted or discharged within four hours of attendance in ED. The percentage of patients seen within four hours was below the national standard, and typically below the England average. Problems with patient flow through the hospital have led to a high number of patients waiting in the department between 4-8 hours. Many patients who were not admitted were being seen within 2 – 3 hours.

There was no system in place to help identify patients with a learning disability.

The service was working with partners to meet service demands, for example, a GP service for minor illnesses, in-reach mental health and therapy services and also was the specialist ED service for patients who had had a stroke.

Translation facilities were available if required. There was a clear understanding of the needs of patients living with dementia, and relatives were able to stay with them while in the department.

Complaints were dealt with appropriately by the trust, all patient complaints were seen by the chief executive.

Service planning and delivery to meet the needs of local people

- The ED served the community of Winchester and Eastleigh and surrounding villages. The nearest minor injuries unit was at Andover. The ED provided a service 24 hours a day for adults and children. It was the lead receiving unit in the trust for patients with stroke. Consultants were in the department for at least 16 hours per day and were also available outside this if required. The ED provided facilities for resuscitation, major injury or illness as well as minor injuries. The service was appropriately staff by doctors and nurses with additional skills and training. The nearest major trauma centre was at Southampton General Hospital.
- The triage room was adjacent to the waiting room to allow for rapid assessment of patients.
- A GP service operated by Southern Health NHS Foundation Trust was available for patients attending with minor illnesses. This service was only operational out-of-hours.
- The trust liaised with the local NHS mental health services to provide psychiatric assessment services. There was a named mental health practitioner who was available on weekdays. This link would assist the department with patients who were assessed as needing to be detained under the Mental Health Act.
- The trust had an 'in reach' therapy service which provided assessment for patients with complex needs. The service was successful at helping ensure elderly patients could be discharged home from the department. This service did not run at weekends.
- The hospital also employed two Hospital ambulance liaison officers (HALO) via another provider. These were trained ambulance personnel who were able to take handover from ambulance staff and care for patients if

there were patients on trolleys waiting in the department. This allows the ambulance to be released to respond to emergency calls. This service works between 10.00am to 10.00pm with a cross over shift covering 12am to midnight, seven days a week.
- The ED was designed so that there were separate facilities for adults and children. The children's waiting room was separate from the main waiting area, with toys and appropriate seating.
- A patient brought to the department with an untreatable condition would be given end of life care in a cubicle in the short stay ward. This was ensuite, had seating for relatives and provided an appropriate environment for the care of a patient in their last hours of life.

Meeting people's individual needs

- The main waiting room was equipped with accessible toilets; these had facilities for changing babies. There was a vending machine available for snacks, and water was available for patients and relatives in the waiting room.
- The waiting room had been recently updated and had a waiting area with sufficient suitable seating for patients and relatives. There was a separate waiting area for children.
- There was a waiting room set aside for children located off the main waiting area, next to the triage room. This room was decorated age-appropriately and had a selection of toys
- Translation services were available over the telephone for patients who were unable to communicate in English. This service could be accessed by staff 24 hours a day and was provided by an external contractor.
- There was not a passport system in use to help identify patients with a learning disability.
- The department had a resource box for patients living with dementia. There was also a sunflower symbol attached to the notes to discreetly communicate to other staff that the patient was living with dementia.
- There was a box of resources for use with patients who were at end of life in the department. This included access to reduced rate parking for relatives.

Access and flow

- Black breaches occur when an ambulance has arrived with a patient but it is not possible to handover the patient to ED staff. The trust reported 457 black breaches over the period January 2014 – April 2015. Nearly half of these (48%) occurred in the five months from October 2014 to February 2015. A lack of bed availability in the hospital was the main reported reason for this.
- Ambulance waiting times delays to handovers greater than 30 minutes occurred across the trust on 748 occasions.
- Patients who were not admitted were seen quickly as data showed that the average total time patients' (admitted and non-admitted patients) spent in ED was 1 hour 55 minutes, significantly lower than the England average of 2 hours 15 minutes (November 2013 – January 2015).
- Patients who had to be admitted had longer waiting times. The trust was not meeting the national emergency access target for 95% patients to be admitted, transferred or discharged within 4 hours. Data from January 2014 to January 2015 showed that this target was only met on five out 13 months. The average over this period was 92.3% (the range was 81% to 97%). The trust was also below the average for England for each month from August 2013 to January 2015.
- Problems with patient flow through the hospital had led to a high number of patients waiting in the department between 4-8 hours. From January to April 2015 approximately40% of patients waited between 4 – 12 hours in the department.
- Patients leaving without being seen was reported as below the England average and typically below 2%
- The nurse in charge attended a trust bed meeting twice a day to share the capacity of the emergency department and understand bed availability across the hospital and other sites. In the event of there being poor availability of beds across the hospital, the frequency of these meetings increase.

Learning from complaints and concerns

- There was no information in the waiting room to inform patients how to make a complaint. Staff advised us that they give patients who express a concern a PALS leaflet.
- Complaints were appropriately managed by the trust. All patients who raised a complaint against the trust received an apology from the chief executive.
- A complaint was received by the department about a patient missing a meal as there was a breakdown in communication. This system has now been improved to ensure that patient meals are not missed.

Urgent and emergency services

Are urgent and emergency services well-led?

Good

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care

We rated this well led as 'good'.

The department had a vision and strategy for the planned future of the service. Governance arrangements were appropriate, risks and quality were being regularly monitored and escalated if needed. The department's staff were positive and engaged. They described the department as having a strong open culture with mutual trust and respect across the staff team.

Senior staff found the Chief Nurse to be accessible and approachable. Senior doctors and nurses provided good supportive leadership and staff told us they were approachable. All staff told us that the ED had a culture of openness and that the teamwork and ethos were excellent. There was evidence of innovate practices.

Vision and strategy for this service

- The service had a clear vision for the near future. This included primary healthcare provision across 24 hours. It also included an expansion of ENP service to increase capacity in seeing patients with minor injuries, and the development of MAP's within the department.
- Some staff discussed the possible future impact of the planned critical treatment hospital. They recognised that it could be years before this strategy would be realised.

Governance, risk management and quality measurement

- Governance processes were robust within the department, with learning shared across roles and the two main departments. As the consultants worked across the EDs in Basingstoke and Winchester they provided an important link in sharing learning from incidents.
- There was combined risk register for the A&E departments across the trust. This clearly identifies risks within the department. The highest risks were around patient flow in the department and maintain safety, quality and the impact on finance from four hour breaches and also on staffing. The recruitment of doctors was an identified risk and recruitment was on-going. The risk register also identifies mitigations and subsequent actions that needed to be taken. For example, the department's risk register identified that no specific handover tool was being used, there was a plan to devise and implement one. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated. The higher risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee
- Governance meetings were held regularly and were attended by medical and nursing staff. Mortality and morbidity meetings took place to ensure that learning from incidents occurred.
- Internal audits took place regularly on infection control and environmental checks. The department fully participated in College of Emergency Medicine audits that were facilitated by a consultant.

Leadership of service

- Nursing leadership was strong, there was a senior nurse acting as matron, supported by a senior matron based in Basingstoke. There was also strong medical leadership from the lead consultant and her team. Junior doctors told us that they felt well supported by the consultants in the department. They would recommend the department as a place to work.
- The leadership team were proud of the warm and friendly atmosphere in the department. All staff we spoke with identified a strong team ethos as being one of the major features of the department.
- Staff reported that they were listened to, and would feel safe to raise concerns to senior staff.
- The senior team at the trust such as the Chief Nurse was approachable and contactable if needed. Staff reported that the chief executives blog was a useful communication.

Urgent and emergency services

Culture within the service

- We found the culture in the emergency department to be open to new ideas and learning from incidents. The team were supportive of each other and staff were happy to report concerns. Staff reported that teamwork and the ethos of the service was excellent.
- Junior doctors told us that the consultants worked well with their counterparts in medicine and surgery.
- Nursing and medical staff were fully aware that they were required to cover both sites when necessary. The consultants and senior nursing staff worked across both hospital sites and cross working was being encouraged with nurses.

Public engagement

- The acting matron of the department kept copies of patient feedback and letters of comment or complaint. Details of the friends and family test were available around the department.

Staff engagement

- The staff across the department were actively engaged and proud of the service they delivered. They were particularly proud of the caring ethos of the department that was facilitated by excellent teamwork.
- Staff engagement was high despite the pressures on the service and changes to nursing leadership. Senior staff met regularly with departmental staff both clinical and managerial to discuss any issues of concern or update. The CEO had an 'open door' policy and was easily contactable.

Innovation, improvement and sustainability

- The department team supported the culture of continuous improvements to practice. All roles of staff actively participated in local and national audits.
- The ED participated in research projects and trials such as CRASH3 and Paramedic2. The CTKUB pathway was designed to allow (well) patients with kidney stones to be discharged home and investigated as an outpatient.
- The department had developed a structured approach to the medical handover of emergency patients that was now in use across the trust.

Medical care (including older people's care)

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

Information about the service

We inspected medical division services at Royal Hampshire County Hospital (RHCH), which is a part of Hampshire Hospitals NHS Foundation Trust.

RHCH provides cardiology, gastroenterology, respiratory medicine, endocrinology, dermatology, general medicine and stroke services including thrombolysis for stroke patients in hyper acute stroke unit (HASU) within the medical services. The hospital also provides services to elderly patients and those living with dementia. There is a 46-bedded acute medical unit (McGill AMU) and admissions and discharge lounge. The hospital was the designated receiving unit for patients who had had a stroke.

We inspected the McGill AMU, HASU, stroke ward (Twyford ward), elderly care and dementia wards (Freshfield and Wykeham wards), general and speciality medicine wards (Clarke, Shawford and Victoria wards), rehabilitation ward (Clifton ward), the endoscopy unit and admission and discharge lounge

During this inspection we spoke with approximately 36 patients, including their family members, 54 staff members including clinical leads, service managers and matrons, ward staff, therapists, junior doctors and consultants, and other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

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

Process and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents. Themes from incidents were discussed at ward meetings to effect learning. The environment was clean and equipment was well maintained. Staff had good access to equipment needed for pressure area care. They were able to order bariatric equipment within 24hours. Infection control practices were followed although needed to improve on some wards. Staff across all services described anticipated risks and how these were dealt with.

Patients whose condition deteriorated were appropriately escalated. The incidence of pressure ulcers and falls was higher than expected. Action was being taken on ensuring harm free care

Safeguarding protocols were in place and staff were familiar with these.

Medical staffing, across the medical services, was appropriate and covered medical outliers well. There was a significant shortage of nursing staff on the medical and care of elderly wards. The trust was using bank nurses where shortages were identified. However,

Medical care (including older people's care)

we found that safer staffing levels at night were not always met on the care of the elderly ward, Freshfield and Victoria medical ward. The trust was implementing actions to mitigate and reduce the risks.

There were appropriate procedures to provide effective care. Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines. Patient outcomes overall were similar to or better than England average for stroke care, diabetes care and heart attack. Were outcomes were worse than the England average, there was an action plan to address areas where improvements.

Arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. Patients had access to services seven days a week and were cared for by a multidisciplinary team working in a coordinated way. When patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements. However, the capacity assessments were not always documented or regularly reviewed in patient care records.

Staff had received statutory and mandatory training, and described good access to professional development opportunities.

Patients received compassionate care that respected their privacy and dignity. They told

us they felt involved in decision making about their care. We found staff were caring and

compassionate. Without exception, patients we spoke with praised staff for their empathy,

kindness and caring.

Bed occupancy in the trust was below the England average It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. There were no medical outliers at the time of our inspection. Hospital data demonstrated the hospital routinely had medical outliers. Staff told us these patients were regularly assessed and followed by a team of medical consultant and junior doctors. Patient bed moves happened frequently, including at night. Staff were ensuring that patients with lower dependency needs were moved and patients had not expressed concern about their moves.

The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target and the 62-day referral-to-treatment target, although this had not been met in June 2015. The medical services were consistently achieving the 18-week referral-to-treatment time target against a national target 90%.

Patient discharges were discussed by medical teams daily. Discharge arrangements were supported by discharge coordinators. The hospital had an increasing number of delayed transfers of care to community services. The trust was working with its partners to improve this

Support was available for patients living with dementia and patients with a learning disability. We

were given examples of the trust working closely with other local mental health NHS teams to meet the needs of patients in vulnerable circumstances.

The medical service had identified a long-term strategy and priorities around improving the services. There were effective governance arrangements and staff felt supported by service and trust management. Lessons from incidents and complaints were usually shared within the staff.

The culture within medical services was caring and supportive. Staff were actively engaged and innovation and learning was supported. There was good local leadership at ward level. Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy.

Medical care (including older people's care)

Are medical care services safe?

Good

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

We rated safe as 'good'.

Processes and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents. Themes from incidents were discussed at ward meetings and staff were able to give us examples of where practice had changed as a result of incident reporting. Staff described an ethos of openness and transparency in responding to incidents but were not consistently aware of the additional requirements of the Duty of Candour in handling incidents.

There was a higher number than expected of pressure ulcers and falls, and in response the trust had introduced care bundles. Patients who were at high risks were clearly identified and had comprehensive action plans.

The environment and equipment were well maintained. Equipment was checked regularly to ensure it continued to be safe to use. Staff had good access to equipment needed for pressure area care, and were able to order bariatric equipment within 24 hours There were daily checks of resuscitation equipment in most of the medical wards and these checks were documented.

Infection control practices were followed although needed to improve on some wards. The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile were low when compared with trusts of similar size and complexity.

Medicines including controlled drugs were mostly managed and stored appropriately. Patient records were well maintained and completed with clear dates, times and designation of the person documenting.

There were no medical outliers (patients placed on wards other than one required by their medical condition) on surgical and other non-medical wards at the time of our inspection.

Patients were appropriately escalated if their condition deteriorated. Staff had good knowledge about safeguarding patients and were aware of the procedure for managing major incidents, winter pressures on bed capacity and fire safety incidents.

Medical staffing, particularly at consultant level cover across the medical services, was appropriate and covered medical outliers well. There was a significant shortage of nursing staff on the medical and care of elderly wards. We found that safer staffing levels at night were not always met on the older people's wards. The trust was trying to use bank nurses where shortages were identified, and more healthcare assistants, and staff were working longer hours and transferring wards to meet minimum staffing levels. However, staff on the elderly care ward told us this presented a risk to patient safety and as these were elderly patients, many were living with dementia. The incidence of falls was higher than on other medical wards. The trust was implementing actions to mitigate and reduce these risks. The management team told us of various measures, such as open recruitment days and overseas recruitment initiatives they had put in place in an effort to decrease the vacancy factor. The trust had also implemented other innovative ideas such as promoting band 2 staff to do more skill based jobs which helped in alleviating the pressure on the nursing staff. Patients on the older people's wards reported that their care needs were being met and we observed this on our inspection.

Incidents

- The medical services reported 44 serious incidents through the National Reporting and Learning System for the period May 2014 to April 2015. Of these incidents, grade three and four pressure ulcers and slips, trips or falls accounted for the highest number of incidents.
- Staff stated they were encouraged to report incidents. Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. They were able to give us examples of range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls.
- Staff told us they received feedback on the incidents they had reported. Minutes of monthly ward meetings confirmed that the themes of incidents were fed back to staff.
- Themes from incidents were discussed at ward meetings in most of the wards and staff were able to

give us examples of where practice had changed as a result of incident reporting. We were given an example of an incident related patient in McGill acute medical unit (AMU).The patient had developed a nasal sore after being on bi-phasic positive airway pressure ventilator (BIPAP).In response to this incident the unit had ordered full face masks which would reduce the risks of developing nasal sores. The unit had also developed a skin care bundle with special emphasis on 'face care' for patients on BIPAP. We observed nurses in McGill AMU using this skin care bundle for patients who required it.

- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place, and action plans were developed to reduce the risk of a similar incident reoccurring. For example, there were action plans in response to high number of falls.
- Learning from incidents was also shared across the trust via the route of the trust's monthly bulletin and staff newsletter.
- Medical services held monthly mortality and morbidity meetings across RHCH and Basingstoke and North Hampshire Hospital (BNHH). Records of the mortality and morbidity meetings minutes showed that any death that had occurred in the department was reviewed, root cause analysis following incidents were discussed, and any lessons to be learnt were shared across the two hospitals.
- Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a severe or moderate level of harm. Nursing and medical staff across most of the services we visited were unfamiliar with the requirements of the Duty of Candour legislation. All staff who we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. Staff were aware of the importance of investigating incidents and potential mistakes but were not aware that the Duty of Candour now made meeting the patient/family and sharing the findings of investigations a legal requirement.

Safety thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (blood clots) and falls.
- All wards had information displayed at their entrance about the quality of the service and this included Safety Thermometer results. There was information about infection control measures, results of NHS Friends and Family Tests, numbers of complaints, levels of staff absenteeism, mandatory training update, and numbers of patient falls, hospital acquired pressure ulcers, new catheter related urinary tract infections and new venous thromboembolisms (This information was presented in a format that could be easily understood by the general public.
- The safety thermometer audit data demonstrated that there had not been a consistent reduction in the prevalence rate of new pressure ulcers and falls during July 2014 and June 2015 and there were periods of both reductions and then periods of increases.
- The medical division performance and finance report (July 2014 – June 2015) identified that the number of falls was higher than the trust target (123) although falls with moderate, severe harm or death was within expected numbers (overall 3 per month). The figures for falls with harm had increased in February and March 2015. The number of hospital acquired grade 2, 3 or 4 pressure sores was overall three to four times higher per month than the expected target of 5 per month. The VTE risk assessment for 95% of patient was being achieved.
- In response to high number of incidents related to pressure ulcers, the trust had conducted pressure ulcer awareness training for staff. Pressure ulcer care bundle and risk assessments had been developed and access to a tissue viability nurses was facilitated. Each of the medical and care of elderly ward had a 'pressure ulcer' resource folder which had updated information on management and suggested action plan for pressure ulcers.
- In response to high number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification of falls by using a falls risk assessment and implementing comprehensive action plans. Throughout our inspection we observed that the patients at high risks of falls were clearly identified and actions to minimise the risk were taken. For example non-slip socks and low level beds were used on the care of elderly wards. Patients' relatives were also encouraged to bring the most suitable footwear for the patients and educational advice for patients and relatives on various aspects of falls were displayed in ward areas

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards.
- We observed a high degree of compliance with hand hygiene, isolation procedures and the correct use of personal protective equipment (PPE), such as gloves and aprons on most of the medical and care of elderly wards.
- Staff adhered to the trust 'bare below the elbows' policy in clinical areas.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinical environment.
- There were isolation procedures and protocols in place around the use of side rooms or cohort bays and we observed these being used appropriately.
- Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection in the hospital. The percentages of staff who had completed the infection control training varied across the medical services. The data provided by the trust demonstrated that in most of the areas within medical services, 64% - 100% of staff had completed the training by June 2015. In the cancer service, which was a part of the medical services, the compliance of infection control training for medical staff was low at 50% against the trust's target of 80% by June 2015.
- Equipment was cleaned however was not marked as ready for use, except for the commodes which were marked with 'I am clean' stickers. Clean and dirty equipment were not segregated appropriately and staff lacked knowledge about assurance process for distinguishing between clean and dirty equipment.
- Standards of cleanliness were monitored. All of the medical and care of elderly wards participated in the monthly infection control audits. There was an action plan to address where improvements were identified on most wards. For example the compliance for hand hygiene procedures was identified as low in Twyford ward. The need for care plans for peripheral cannula care and catheter insertion was also lower than expected on most wards. A clear action plan was put in place to address this concern and there were plans to follow up on this in the next audit cycle.
- The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and for Clostridium difficile were lower when compared to trusts of similar size and complexity. Patients admitted to the hospital were screened for MRSA. As of June 2015, medical services did not have any case related to MRSA and had six cases related to Clostridium difficile.
- The Twyford ward environmental audit (March 2015) demonstrated full compliance with infection control standards with an overall standard of 91% (above the 85% target); the ward environment score, however, was only 79% and actions were identified to address this.

Environment and equipment

- We observed that each ward had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due.
- There were daily checks of resuscitation equipment on most of the medical and care of elderly wards and McGill AMU, and these checks were documented. However the resuscitation trolleys were not sealed or tagged on Victoria and Freshfield ward. This meant that the resuscitation trolley could have been opened and thus may not be fully ready for emergency use.
- Equipment such as commodes, bedpans and urinals were readily available on the wards we visited.
- Ward staff told us they had good access to equipment needed for pressure area care. Bariatric beds and mattresses were not stored on the hospital site but were available within 24 hours from the equipment library when required.
- We observed elements of dementia friendly design was incorporated into the care of elderly ward areas, for example colour coding system was used for different bays and pictorial signage was being used.
- On Victoria ward there was a three bedded female bay which did not have washing or bathroom facilities. The female patients in this bay could only use the washing

and bathroom facilities available in another female bay and had to walk across a male bay in order to access those. This was compromising patients' dignity as patients sometimes were in their night attire.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges when necessary. Checks on the temperature of medicines fridges were completed daily on all the wards we visited except on Freshfield and Victoria wards where gaps in the daily checks were identified.
- Controlled drugs were mostly managed and stored appropriately. On two medical wards we observed that control drugs in liquid form, which were in use did not have an opening date on the bottle. Ward staff on these wards were not aware that any liquid medicines required a documented opened date to ensure medicines remained in optimal condition and used within the recommended time once opened.
- Patients' medication charts clearly identified any known allergies to reduce the risk of being given inappropriate medication.
- There was a good system of electronic prescribing across the trust. Staff we spoke with told us the support from pharmacy service was good. AMU had a ward based pharmacist and pharmacy technicians. Most of the medical wards had support from pharmacy technicians to assess and maintain patients' own drugs (POD). Pharmacy staff were accessible to dispense medicines and facilitate discharges.
- Ward sisters were aware of medicine incidents which happened on their wards and the learning they took from these incidents.
- Patients told us they were usually given their medicines on time. They also said medicines were explained to them and they were told about risks associated with taking medication.
- We observed staff giving patient's their medication only after the correct checks were made. Nurses undertaking drug rounds were protected from interruptions. Staff had good access to information about medicines on the trust intranet.
- The trust antimicrobial prescribing policy was being adhered to for outliers.

Records

- The trust had recently introduced new patient care records for nursing staff. The new records were in paper format and included various risk assessments such as venous thromboembolism (VTE), falls, malnutrition and pressure ulcers. Nursing staff told us that the new care records promoted more patient centred care and found them beneficial for patients.
- Due to the introduction of new paper records for nurses, different notes were held by healthcare professionals. For example; medical and nursing staff documented in separate sets of patients' records. The trust was aware of this and had plans to introduce a combined set of patients' records.
- We reviewed 21 patient care records across different medical and care of elderly wards. Patient records were well maintained and completed with clear dates, times and designation of the person documenting. The records we reviewed were written legibly and assessments were comprehensive and complete, with associated action plans and dates.
- The admission notes were legibly documented by medical staff in keeping with general medical council (GMC) guidance which included recording patient concern, details of any actions taken, information shared and decisions made relating to those concerns.
- Separate documents within the notes were available for patients presenting with sepsis, stroke and transient ischaemic attack (TIA).The appropriate risk assessments were completed for patients at risk of pressure ulcers or falls.
- The medical records of these patients demonstrated that they were reviewed regularly by medical consultants and junior doctors.
- Patient records were not always stored in a way that maintained confidentiality. Records were often stored in notes trolleys in ward areas. Although these trolleys had the facility to be locked, we observed unlocked and unsupervised trolleys of patient records were kept in the corridors on Freshfield and Clifton wards when not in use. These were easily accessible to patients and visitors.

Medical care (including older people's care)

Safeguarding

- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. Staff were able to explain the types of concerns which would result in a safeguarding alert being raised.
- The clinical areas had allocated a safeguarding leads who staff could access for support and advice, although not all staff we spoke with were aware of this.
- Staff told us they had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy.
- The percentages of staff who had completed the safeguarding training varied across different disciplines and service types within the medical services. For example; 90% of nursing staff working in speciality medical services had completed adult safeguarding training as of June 2015.The percentages of nursing staff completing the same training within cancer services which was a part of medical services was low between 55% to 76%.This was against the trust's target of 80%.
- Staff told us safeguarding concerns were reported as incidents and any concerns would be discussed in handover meetings and shared across the team.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, conflict resolution, consent and information governance training. Most of the staff told us they were up to date with their mandatory training. Staff received an electronic reminder when the training was due.
- The data provided by the trust showed us that the compliance with mandatory training varied across the medical services with some areas and teams demonstrating higher compliance in completing mandatory training than others. The range of percentages of staff completing their mandatory training varied between 22% to 100%, with most of the teams achieving compliance between 80% to 100% against the trust's target of 80%.The compliance of completing mandatory training was particularly low in cancer services.
- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs. Data provided by the trust indicated that in the last 12 months between 60% to 100% of staff in the medical services had corporate induction.

Assessing and responding to patient risk

- Risk assessments were undertaken for individual patients in relation to venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the risks identified.
- There were clear strategies for minimising the risk of patient falls on the McGill AMU and other medical wards. Staff on these wards demonstrated a good understanding of the causes of falls and how to avoid them.
- The medical wards and the AMU used the National Early Warning Score (NEWS), a scoring system that identifies patients at risk of deterioration or needing urgent review. These scores were recorded on an electronic device. Medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. The completed NEWS charts we looked at showed that staff had escalated patients appropriately. Repeat observations were taken within the necessary time frames.
- Nursing handovers occurred at every shift change, during which staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients. Nursing staff felt well supported by doctors when a patient's deterioration was acute and resulted in an emergency.
- Guidance from London Quality Standard (2013) suggest that all emergency admissions should be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital. The medical staff and the service leads confirmed that this guidance was being met across the medical services.

- Patients admitted at night were either seen by the on call consultant or the next morning by the consultant in charge of their care. We observed that patients with raised NEWS were escalated appropriately to the 'night on call' team.
- There were no arrangements for staff to access a critical care outreach team to support and advise in the care of very sick or deteriorating patients. Nursing staff told us that during day time the access to junior doctors and consultants was good and they were very responsive to very sick or deteriorating patients. The night staff especially felt supported by 'night on call' team and told us their support was valuable and helped in the provision of safe care.
- Although there were no medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition), the data provided by the trust demonstrated that between June 2014 to June 2015 the hospital routinely had medical outliers. Ward staff told us that only the medical patients with lower acuity and lower risks were transferred to other wards. Staff confirmed that risk assessments and documentation for the medical patients were transferred and reviewed on the wards in a timely manner. Staff made all the attempts not to transfer these patients to a different ward unless clinically indicated.

Nursing staffing

- Nursing numbers were assessed using the acuity tool and there were identified minimum staffing levels. The safe staffing levels were displayed at the entrance of every ward, including planned and actual numbers.
- The divisional risk register (May 2015) highlighted nurse workforce vacancies as an 'amber' risk. As of June 2015, there was a 24% vacancy rate for the registered nurses across general medical wards, 11%for registered nurses across care of elderly and stroke wards and 15% for registered nurses for cancer services. Nursing staff turnaround rate between April 2014 to April 2015 was approximately 15% for medical, care of elderly and stroke wards.
- Staffing numbers were identified based on the acuity tool used by the trust. Shifts were agreed in advance against the planned registered nurse to patient ratios required for each shift and these were rated Red Amber or Green (RAG) in terms of staff numbers. Any shifts that could not be adequately staffed on the rota were escalated and reported on. In June 2015, the majority of early/long, late and night shifts were staffed as planned (higher than minimum staffing levels) or were lower than planned but above minimum staffing levels. A few shifts, mainly late shifts, were staffed at minimum staffing levels. There were no red shifts where the nurse staffing level is deemed unsafe. This had been the pattern from January to June 2015.
- However, actual staffing differed to the predicted RAG rating. Staff told us that when staffing levels were not sufficient to meet the care and treatment needs of patients they contacted the matron or nurse on call for the hospital and completed an electronic incident form.
- Bank and agency staff were employed to cover shortfalls in staffing although the staff were not encouraged to use agency nurses regularly. Staff told us there were not always additional staff available through bank to be able to work. We reviewed the staffing rotas and found that gaps could not always be filled. Staffing rotas for the month of June 2015 showed us that on several wards, safer nursing staffing level was not met on several occasions. For example in June 2015, safer staffing levels were not met on Freshfield ward on 19 night shifts and for 24 night shifts on Victoria ward. The trust was not meeting their planned nurse to patients' ratios on these shifts and this was consistently between 1:11 and 1:13 trained nurses to patient. This was below the staffing level recommended by the Royal College of Nursing (2012) of one to seven (1:7) on older people's wards.
- On most of these occasions a higher number of health care assistants were on the rota in place of nurses, to increase numbers as the trust was not able to fill the vacancies using the bank staff. Staff on the wards told us this was a risk to patient safety. For example; Freshfield ward which was a care of elderly ward often had a large number of patients living with dementia and those who were at high risks of falls. Staff on this ward told us that although the ward had falls prevention measures in place, there were occasions at night times where it had been difficult to follow those measures due to insufficient staffing level. The falls analysis sent by the trust demonstrated that Freshfield ward had 58 falls with low harm between January 2015 to June 2015. This number was higher as compared to the other medical wards in the hospital.
- Senior nursing staff monitored staffing levels on each shift. Staff were asked to cover other wards for some or

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

- Senior nursing staff on the wards told us that the low staffing level meant that their supervisory role could be achieved only sometimes as they were required to fill the staffing vacancy. We observed evidence of this on Freshfield and Victoria ward.
- Staff told us 'patient safety' and high quality of care was always seen as a priority and they worked extra hours and occasionally compromised on training in order to make sure they always delivered safe patient care and the quality of care was not impacted.
- Patients told us the staff and the units were busy but the nursing staff looked after them and they did not have to wait long for help or care. The nursing handovers which we observed were good. There was a thorough discussion of each patient which included information about their progress and potential concerns.
- The management team were aware about the challenges associated with the nursing staffing level in the hospital. They told us of various measures, such as open recruitment days and overseas recruitment initiatives they had put in place in an effort to decrease the vacancy factor. All ward based staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- The trust had also implemented other innovative ideas which helped in alleviating the pressure on the nursing staff. For example; the trust had promoted band 2 staff to do more skill based jobs such as activity coordinators, nutritional and hydration assistant and rehabilitation practitioners.
- Senior nursing staff indicated that the escalation process on staffing issues could be unnecessarily lengthy at times. The trust planned to make changes around the overall nursing structure by making the senior nursing staff ward based, and clinically focussed to help with staffing challenges and oversight of the ward.
- During our inspection nurse staffing on the elderly care wards was below minimum but care was meeting safety standards, patient call bells were being answered promptly and staff were attended to the patient's care needs.

Medical staffing

- There was a consultant cover on the AMU from 8am – 4pm seven days a week. Consultant ward rounds on McGill AMU took place twice a day. During the day all new patients on the AMU were seen by a consultant within one hour following their admission.
- Staff told us there were sufficient consultants and doctors on the wards during the week. Junior doctors felt there were adequate numbers of junior doctors on the McGill AMU and wards out of hours and that consultants were contactable by phone if they needed any consultant support.
- As of September 2014, the total medical staffing number within medical services across the trust was 191 whole time equivalents, of which 38% were consultants, 4% middle career, 29% specialist registrars and 29% junior staff at foundation year one and two. The data provided by the trust demonstrated that as of September 2014 the trust had a higher number of medical consultants and junior doctors compared to national level. As of June 2014, the vacancy rate for care of elderly consultant or equivalent grades was 3%.There were no other vacancies for consultants across other medical specialities.
- Guidance from the Society for Acute Medicine and the West Midlands Quality Review Service (2012) suggests that a consultant should be on site or be able to reach the acute medical unit within 30 minutes. The medical staff and the service leads confirmed that this guidance was being met across the medical services.
- There was a doctor trained in the speciality of General Internal Medicine or Acute Internal Medicine at level ST3 or above, or equivalent staff and associate specialist (SAS) grade doctors, available at all times on the McGill AMU, in line with the above guidance.
- On the medical and care of elderly wards, patients were seen by a consultant twice a week except on the Shawford ward (respiratory ward) where patients were

seen daily by a consultant. Over the weekend, there were two on call consultants who saw all new patients and acutely ill patients on McGill AMU and medical wards.
- Nursing staff told us that medical patients who were on surgical wards were regularly reviewed by junior doctors and medical consultants.
- All the doctors were trained in advanced life support (ALS).

Major incident awareness and training

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

Are medical care services effective?

Good

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

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

We rated effective as 'good'.

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

Excellence (NICE) guidelines. There was good participation in national audits. Patient outcomes overall were similar to or better than England average for stroke care, diabetes care and heart attack. Where outcomes were worse than the England average, there was an action plan to address areas for improvement.

Patient outcomes were monitored by individual services and information about these outcomes

was included in the trust's clinical governance reports. Staff had access to specialist training

courses and had appraisals, but clinical supervision for nurses was not well developed. Staff worked in multidisciplinary teams to coordinate patient care.

Patients' pain and response to pain relief was appropriately monitored and patients were given pain relief when they needed it. Patients at risk of malnutrition or dehydration were risk-assessed by appropriately trained and competent staff, and referrals to and assessments by dieticians or speech and language therapists were made within expected timescales. Patients were supported to eat and drink by the use of nutritional assistants on some wards.

The trust had made significant progress towards seven-day working. There was medical consultant cover on the acute medical unit (AMU) seven days a week. There was adequate medical presence on all the medical and care of elderly wards seven days a week. Staff received training and this included training to support people living with dementia. Staff told us they had good access to patient-related information and records whenever required. Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received.

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

Evidence-based care and treatment

- Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw evidence of discussion on NICE guidelines in patients' health care records such as guidelines related in management of diabetes, heart failure and stroke.
- Policies were accessible for staff and were developed in line with national guidelines, such as the pressure ulcer prevention and management policy. Staff we spoke with were aware of these policies. Patient records we reviewed showed risk assessments and care plans for patients who were at risk of developing pressure ulcers.
- There were integrated care pathways based on NICE guidance for stroke patients and a specific protocol was used for the treatment of thrombolysis in the hyper acute stroke unit.

- There were specific pathways and protocols for a range of conditions, including diabetic ketoacidosis, heart failure, and respiratory conditions. The trust had clear pathways for patients with sepsis or acute kidney injury to enable early recognition, prompt treatment and clinical stabilisation.
- The endoscopy department had been awarded Joint Advisory Group accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance.
- The medical services participated in all national clinical audits that it was eligible for to measure the effectiveness of care and treatment provided. The audits included a heart failure audit, the Myocardial Ischaemia National Audit Project, the Sentinel Stroke National Audit Programme and the National Diabetes Inpatient Audit.
- The medical services had a formal clinical audit programme in which compliance with NICE guidance was assessed and the areas that had partial compliance were reviewed and action plans were made. The data provided by the trust showed there were 21 NICE guidelines listed under the medical services. The medical services were compliant with 16 out of 21 NICE guidelines. Action plans were in place to review compliance with the remaining five guidelines with which the service was partially compliant.
- The service conducted several local audits, such as environmental audits, audits of infection control practices and cleaning audits. There was evidence of improvement as a result of audit, for example, the introduction of the upper gastrointestinal bleeding proforma to prompts risk assessment with the Blatchford Score and advise appropriate risk assessment, discharge/referral and management.

Pain relief

- We observed nurses and doctors monitoring the pain levels of patients and recording the information. Patient pain was monitored as part of their regular observational check. Pain levels were scored using the National Early Warning Score (NEWS) chart.
- For patients who had a cognitive impairment, such as dementia or a learning difficulty, staff used the 'Abbey Pain Scale' to aid their assessment. This scale was developed for patients with communication difficulties who were unable to verbalise how much pain relief they require.
- Patients we spoke with told us they were given pain relief when they needed it and nursing staff always checked if it had been effective. We heard discussions about reviewing pain medications of an acutely ill patient in the McGill AMU. Staff had good knowledge of pain management which they recorded on patients' records. This ensured that patient's needs were being discussed and provided.
- There was a patient group directive for nursing staff to prescribe pain relief and this was being used appropriately.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the medical wards. We observed that fluid balance charts were used to monitor patients' hydration status. Care of elderly wards and medical wards had detailed fluid balance charts informing clinical decisions.
- The 'Malnutrition Universal Screening Tool' (MUST) was used in all the wards and medical units. Patients who were nutritionally at risk were referred to a dietician.
- Speech and language therapists were available on the stroke ward to check that patients could swallow safely and to offer advice. Instructions from speech and language therapists were recorded in patients' records and care plans.
- A colour-coded tray system was used on all medical and care of elderly wards and units to identify patients who needed help with eating and drinking. All patients had access to drinks which were within their reach. Care support staff checked that regular drinks were taken where required.
- We visited medical and care of elderly wards at mealtime. We observed that nursing staff and nutritional support assistants were giving assistance to feed the patients who needed support. Patients were given encouragement to take adequate oral fluids.
- Nursing staff on care of elderly wards told us they often get support from meal time volunteers three times a week who assisted the patients with meals. However, we did not observe mealtime volunteer support when we visited these wards.

- Patients told us they were always given choices for food and snack menu. On the care of the elderly wards they had small food-only refrigerators which contained fresh cakes and snacks for patients. Most patients were highly complimentary about the quality of food provided.

Patient outcomes

- The hospital's mortality rates were within expected range.
- Staff followed care pathways for conditions such as sepsis and acute kidney injury.
- The trust contributed to the Sentinel Stroke National Audit Programme (SSNAP). The audit is based on 10 domains of both patient centred and team centred (organisational) indicators for example, for assessment, multi-disciplinary treatment and discharge. The combined indicator for RHCH was level C (October 2014 to December 2014) which the average score (A being best and E being the worse) and was similar 21% of the other NHS trusts nationally for the same time period. For October 2014 to December 2014, the hospital performed better than other trusts for meeting standards for specialist assessments, thrombolysis and provision of physiotherapy and occupational therapy and discharge processes. The hospital was similar to other trusts for care on the stroke unit, multi-disciplinary working and standards of discharge standards. The hospital performed significantly worse than other trusts in providing speech and language therapy and scanning.
- Action plans were developed and implemented following the outcomes for the audit. For example, the provision of speech and language therapy for stroke patients was increased following the audit results. There was a speech and language therapist based on the Twyford ward between 9am to 5pm, Monday to Friday and was available to assess new patients over the weekends. The trust was evaluating and monitoring the performance of the stroke wards.
- The hospital had mixed results in the 2013-2014 Myocardial Ischemia National Audit Project, a national clinical audit of the management of heart attack. The hospital's performance was better than the national average in non-ST segment elevation myocardial infarction (a type of heart attack) patients seen by a cardiologist or a member of their team. The hospital performed below national average in non-ST segment elevation myocardial infarction patients that were referred for or had angiography.
- The hospital's performance in the National Diabetes Inpatient Audit 2013 was better than the England average for 15 of the 21 indicators. Six indicators were worse than the England average. These were admission for foot diseases, foot risk assessment within 24 hours, after 24 hours and during hospital stay, suitability of meals and staff knowledge for providing emotional support.
- The medical service conducted several local clinical audits such as management of upper gastrointestinal bleeding and cardiac angiogram complication audit. The service had developed action plans in response to these audit outcomes and these were being implemented and monitored.
- Between January 2014 to December 2014, emergency readmissions were within expected range and the standardised readmission rates compared favourably with national rates, except for endocrinology services where they were slightly above national rates.
- Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports. Included in this report was a review of incidents, complaints, general patient safety information, infection control review, sharing from incidents and information. This information was also shared with the ward staff.
- The medical division regular monitored clinical effectiveness indicators on stroke care in its performance report. The trust was meeting the target for over 80% of stroke patients to spend 90% of their time on the stroke ward. The target for 80% of high risk TIA patients to be seen on the same or next working day was not met for ten out of 12 months. The trust identified that the target was not being met for nine out of 12 months for stroke patients to have direct admission to the stroke ward (July 2014 - June 2015).

Competent staff

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.
- Staff told us they had regular annual appraisals however the data provided by the trust demonstrated that between April 2014 to April 2015 the appraisal

completion rate varied between different medical services and different staff disciplines. For example, 100% of the medical staff who were consultants or equivalent grades had completed an appraisal. The appraisal completion rate for nursing staff who were band 7 or below was between 33% to 66% on medical, care of elderly and stroke wards which was lower than trust targets.

- Nursing staff told us they not receive formal supervision. Staff however were supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities. This meant that the nursing staff did not get a regular opportunity to reflect regularly on clinical practice and development needs. Therapy staff received regular supervision sessions.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example staff on the stroke ward had completed dysphagia awareness training and training for undertaking swallowing assessment.
- Care of elderly wards had a regular input from a dementia specialist nurse. Most staff on these wards had attended dementia training. A selected number of staff were trained to become dementia champions on the medical and care of elderly wards we visited.
- Nursing staff told us they felt they had the training to ensure they had the specialist skills required to offer specialist interventions. For example; nursing staff on Shawford ward (respiratory ward) had attended training on 'non-invasive ventilators' and were encouraged to attend 'acute deteriorating patient course' which was run by the trust. Nurses reported concerns that on occasions staff shortages prevented them from attending training.
- Staff commented positively about the training opportunities and education packages for staff development and we heard several examples where the trust had supported staff in undertaking training programmes from a local college or university. For example, a member of housekeeping staff was supported to undertake level 2 dementia training from Basingstoke College as they had developed an interest in caring for patients living with dementia on the ward.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors rated their overall satisfaction with training as similar to other trusts.
- Trainee doctors we spoke to said they were well supported and they felt hospital was a safe place to work.
- The therapy staff on the medical wards told us that they attended in-service training once a week and the junior physiotherapy staff also received weekly teaching related to their speciality.

Multidisciplinary working

- Staff described integration across the three sites of the trust as 'good'. This had allowed for improved coordination between medical services and better management of patient care and treatment. For example; the therapy staff and consultants from the stroke team worked across Royal Hampshire County Hospital (RHCH) and Basingstoke and North Hampshire Hospital (BNHH).This improved the coordination of care as some stroke patients were transferred from RHCH to BNNH for stroke rehabilitation.
- Staff told us that multidisciplinary team (MDT) working across the trust was good. Junior doctors and nursing staff told us nurses and doctors worked well together within the medical speciality. We saw evidence of this on the AMU. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- There was evidence of multidisciplinary working on all medical and care of elderly wards and the AMU, which included physiotherapists, dieticians, occupational therapists, speech and language therapists and social workers.
- Multidisciplinary team board rounds took place in each of the ward areas every morning when plans relating to appropriate discharge and reviews of unwell patients were discussed.
- Multidisciplinary team meetings took place on the stroke ward once a week to discuss current and new patients. Staff told us this meeting was attended by various health professionals such as nurses, doctors, physiotherapist, occupational therapist, speech and language therapist and social worker. The patients on the stroke ward were also referred to clinical psychologists if necessary.
- Multidisciplinary team meeting (MDT) took place on care of elderly and medical wards once or twice a week to discuss current and new patients. We attended MDT on Freshfield ward which was attended by consultant geriatricians, junior doctors, physiotherapists,

occupational therapists, nurses, student nurse, dieticians and discharge coordinators. The staff present were able to make a constructive contribution to the meeting and focussed on identifying the patients' needs and treatment planning. Actions plans were completed following the discussion.
- There was dedicated pharmacy support on all the wards we visited.
- Care of elderly consultants told us they regularly attended virtual ward meetings in the community in collaboration with Southern Health NHS Foundation Trust. This meeting was also attended by staff employed by Southern Health NHS Foundation Trust and GPs. Staff told us the attendance at these meetings was a good opportunity to share and receive information about patients, particularly those with complex needs.

Seven-day services

- There was medical consultant cover on the AMU between 8am to 4pm seven days a week. Patients who were admitted after 4pm and at night were either seen by the on-call consultant or by medical consultants the next morning. Nursing staff and junior doctors told us consultants were on-call out of hours and were accessible when required.
- On all the medical and care of elderly wards we visited, consultant ward rounds took place at least twice a week. Over the weekend, all new and deteriorating patients were seen by the on-call medical consultant.
- Consultants worked seven days a week across all the medical wards between 8am to 5pm. Patients who were admitted after 5pm and at night were either seen by the on-call consultant or by medical consultants the next morning. Patients who were admitted to the hyper acute stroke unit were seen by the consultants daily. Patients admitted for stroke rehabilitation on Twyford ward were seen by the consultant twice a week. The on-call stroke consultant would see new admissions and acutely ill patients on the stroke ward over the weekends. The transient ischaemic attack clinic was accessible seven days a week.
- There was a daily consultant gastroenterologist on-call for emergency gastrointestinal (GI) bleeding patients. There was a seven-day endoscopy service available for patients who had experienced a GI bleed
- A seven-day physiotherapy service was available for patients with respiratory conditions between 9am and 5pm.On call physiotherapy service was available overnight for patients with respiratory conditions.
- The medical services had access to radiology support seven days a week, with rapid access to CT scanning when indicated. Magnetic resonance imaging was not available over the weekend
- The pharmacy department was open seven days a week, but with limited hours on Saturday and Sunday. An on-call pharmacist was available to dispense medicines and offer urgent advice over the weekends.
- We were told that medical patients who were on surgical wards were regularly reviewed by medical consultants.

Access to information

- Staff told us they had good access to patient-related information and records whenever required. The bank staff also had access to the information in care records to enable them to care for patients appropriately. All areas used electronic handover sheets to ensure all staff had up-to-date information about patients on their ward.
- There was a patient transfer summary in patients' notes for those who were transferred within the hospital. The transfer summaries that we reviewed in patients' notes were completed appropriately. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received. Ward staff told us these were always sent within 48 hours following patient discharges. This ensured that GPs were aware of their patient's discharge and could offer adequate community support if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding treatment and care patients required. This was particularly observed on care of elderly medicine wards for the patients who had been diagnosed as living with dementia.

Medical care (including older people's care)

- Most of the ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs). Staff were able to seek advice and extra training on MCA and DOLs if that was required. We were given an example on McGill AMU where staff had concerns related to MCA for a young patient with mental health issues. Ward staff were able to get support from a mental health nurse and the ward manager had also arranged bespoke training for staff from a mental health nurse and safeguarding lead.
- However, we found that the capacity assessments were not always documented or regularly reviewed in patient care records. For example; at the time of our inspection three patients on Freshfield ward (care of elderly ward) had Deprivation of Liberty Safeguards (DoLS) in place. The capacity assessment was not completed for one of these patients and the other patient's capacity assessment was not reviewed since eight weeks. This meant that staff were not able to justify whether the decision was made in patient's best interest when they lacked the mental capacity.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Staff were aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty.

Are medical care services caring?

Good

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

We rated caring as 'good'.

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

from patients and their relatives was continually positive about the way staff treated them. Patient

and relative feedback strongly evidenced there was a caring and supportive culture in the medical services. The results of the Friends and Family test between April 2014 to February 2015 demonstrated overall satisfaction of the patients with medical services.

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

Patient's emotional needs were highly valued by staff and were embedded in their care and

treatment. During our inspection we observed that staff were responsive to patients' needs, and we witnessed multiple episodes of kindness from motivated staff towards patients across different medical and care of elderly wards.

Compassionate care

- Results of the NHS Friends and Family Test were displayed on every ward except on Freshfield and Victoria wards. There were posters encouraging patients to give their feedback so that the care provided could be improved. Overall between March 2014 to February 2015, the results showed satisfaction with the service provided. Average response rate of the RHCH for the FFT was below England Average. Between March 2014 to February 2015, 95% of patients were 'extremely likely' to recommend the medical services in RHCH to family and friends which was similar to the national average score.
- The 2014 CQC Inpatient Survey found the trust scored similar to other trusts on all the indicators.
- The 2013/14 Cancer Patient Experience Survey found the trust scored similar to other trusts on 33 out of 34 indicators and better than the other trusts for the remaining one indicator.
- We spoke with 36 patients and relatives of patients on the medical and care of elderly wards. All patients we spoke with said that staff provided a good and caring service.
- We found the care and treatment of patients within all medical wards was empathetic and compassionate. We found staff had developed trusting relationships with patients and their relatives. We were given an example about staff taking a sensitive and supportive approach with a patient who had self-harmed. The patient told us "everyone is nice bearing in mind this is a difficult thing to discuss".

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff communicating with patients in a respectful way in all situations. Staff ensured confidentiality was maintained when attending to care needs. We observed that call bells were answered in a timely manner on most of the occasions.
- Patients told us "the staff are brilliant and provide excellent care" and staff responded quickly to their needs.
- We observed multiple examples where staff demonstrated compassionate and kind behaviour towards patient. For example; on Freshfield ward, we observed staff feeding breakfast to a patient living with dementia who always preferred people's company. The patient was encouraged to sit at the breakfast table near nursing station and there was always a member of staff who would talk to the patient and give them company. Staff members demonstrated a good awareness of this patient's needs who was living with dementia and provided good support showing kindness and unhurried care.
- Staff in multidisciplinary meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care and felt involved in the decision-making process regarding their treatment. Relatives felt they were fully informed about their family member's treatment and care. Patients had been given the opportunity to speak with their allocated consultant.
- Patients and their relatives commented that information was discussed in a manner they understood. Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regard to the way they had been spoken to, and all were complimentary about the way they were treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Patients on the stroke unit told us that they had been involved in developing their care plan, goal planning and understood what was in place for the future management of their stroke. The goals were displayed by the patient's bed on the Twyford ward (stroke ward). The goals were written in user friendly language which encouraged the patient to take ownership of their own goals.
- The trust was encouraging cares and relatives of patients living with dementia to stay with their loved ones while he or she was an inpatient on the ward by offering them a carer's passport. The carers were encouraged to provide care for their loved one, such as help with eating meals or personal care. We spoke with the relatives of patients who found this was a good initiative and beneficial for both themselves and patients.

Emotional support

- During our inspection we observed that staff were responsive to patient's needs, and we witnessed on several occasions patients being treated with kindness from motivated staff.
- On Shawford ward, we observed close attention being paid to the specific requirements of a very ill patient. We heard a conversation requesting the medical team to visit and advised on the further management. The patient's family were included in this conversation and were being supported.
- We observed dementia volunteers on Freshfield ward who were selling newspaper, sweets and were interacting with patients living with dementia. Staff told us that the dementia volunteers visited the ward every single day.
- When patients with complex needs on care of elderly wards were discharged to their new home, they were escorted by a member of nursing or therapy staff to who spent up to an hour with patients in their new home. This had helped in offering elderly patients with emotional support.
- The discharge co-ordinator informed us that when patients with complex care needs were deciding on

their prospective home following their discharge, they were given the opportunity to visit the home and have a meal there. The transport for these visits was organised by the ward.
- Therapy staff on the stroke unit assessed patients using a 'mood assessment pathway' and patients were referred to a clinical psychologist appropriately
- The hospital chaplaincy had a visible presence abound the hospital and were happy to meet people to offer them support.

Are medical care services responsive?

Good

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

We rated responsive as 'good'.

There were good examples of staff and teams working responsively to meet the needs of local people. The acute medical unit (AMU) which also had a GP admission bay and rapid access clinics were introduced to improve the trust's ability to manage the increasing pressures on beds because of an increasing demand.

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

Hospital data demonstrated the hospital routinely had medical outliers. Staff told us these patients were regularly assessed and followed by a team of medical consultant and junior doctors. Patient bed moves happened at frequently, including at night. Staff were ensuring that patients with lower dependency needs were moved and patients had not expressed concern about their moves.

The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target and the 62-day referral-to-treatment target, although this had not been met in June 2015. The medical services were consistently achieving the 18-week referral-to-treatment time target against a national target 90%.

Patient discharges were discussed by medical teams daily. Discharge arrangements were supported by discharge coordinators. The hospital had an increasing number of delayed transfers of care to community services. The trust was working with its partners to improve this.

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

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

Service planning and delivery to meet the needs of local people

- The 46 bedded McGill AMU was open 24 hours a day, seven days a week. The unit was divided into different bays for patients needing specialist input and for those needing general medical care. The unit also included a ten -bedded area where patients with higher medical dependency were admitted. Staff told us the unit was always busy and had alleviated some of the pressures in the emergency department (ED).
- Emergency admissions to medical care services represented the majority of admissions. These were primarily through the ED or GPs. Patients were initially admitted to the McGill AMU for assessment and diagnosis of their condition with a maximum stay of 48 to 72 hours. If a longer stay was required, patients were transferred to the relevant speciality ward. Nursing staff told us that they were usually able to achieve this target length of stay and it was rare that patients were cared for in the McGill AMU for longer periods because of bed pressures.
- The patients admitted in the McGill AMU were regularly seen by speciality doctors such as respiratory, cardiology, gastroenterology or care of elderly consultant, as required. The unit had ward-based therapists seven days a week.
- The McGill AMU had a separate bay where patients could be admitted directly through GPs. The unit followed specific ambulatory care pathways for assessment of deep vein thrombosis, pulmonary

embolism and intravenous antibiotic treatment, which formed the majority of their caseload. The unit also had a rapid access clinic where patients were referred through GPs for diagnostic tests or certain other medical interventions. Staff told us the GP admission bay and rapid assessment clinic was helping to meet the needs of patients in the community who required medical intervention without the need to be admitted to the hospital.

- The medical services also had a nurse led eight bedded day unit in the admissions and discharge lounge for patients who required certain medical interventions such as liver biopsy, lumbar puncture or blood transfusion following their discharge. Patients were referred to this service by the medical consultants and the service was open Monday to Friday. Staff on this unit told us that this service was helping to meet needs of patients who required medical intervention without prolonging their stay in the hospital. We spoke to three patients who were highly complimentary about this service.
- The early supported discharge team helped stroke patients for up to six weeks following their discharge from the hospital. The staff felt that this gave continuity of care and supported the patients in achieving their goals following the discharge.

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Access and flow

- Bed occupancy in the trust was in the range of 73% to 83% for the period between April 2013 to December 2014.This was below the England average of 88%. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- There was a trust-wide operational group responsible for the coordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted. They also discussed any action that was required when wards were at full capacity.
- Senior nursing staff on all the medical and older people wards and McGill AMU attended bed management meetings twice a day. These meetings enabled managers and staff to get updated information on the activity in the ED and the availability of beds on ward areas. This information helped staff to manage patient flow from the AMU to speciality wards.
- The aim of the average length of stay in the McGill AMU was 48 to 72 hours. Staff told us this was frequently achieved. On rare occasions patients stayed in the AMU for four days or longer because it was difficult to transfer these patients to the speciality wards because of capacity issues. There were no patients in McGill AMU who had stayed for longer than 72 hours at the time of our inspection.
- There were no medical outliers at the time of our inspection (patients placed on wards other than one required by their medical condition).The number of outliers varied each day. The data provided by the trust demonstrated (June 2014 to June 2015) that the hospital routinely had medical outliers. Staff told us these patients were regularly assessed and followed by a team of medical consultant and junior doctors. Patients were seen at the weekend if their condition deteriorated or were an emergency admission. The risk assessments and documentation for the medical patients were transferred and reviewed on the wards in a timely manner. Staff made considerable attempts not to transfer these patients to a different ward unless clinically indicated.
- The trust's performance report (July 2014 to June 2015) showed that an average of 125 patient moves took place per month between 10pm and 7:59am. Data provided by the trust demonstrated (April 2014 to March 2015), 34% of the patients had moved wards at least once, 8% of the patients had moved wards at least twice and 2% of the patients had moved wards more than three times during their hospital stay.
- Staff told us that bed moves happened all the time. Bed moves were monitored at the ward level and centrally at the trust level. Wherever possible staff tried hard to ensure that patients who were moved were generally more stable, and had lower dependency and acuity needs. Patients told us that often they had moved wards more than twice and even at night. Patients however did not express any concerns about the continuity of nursing or medical care associated with bed moves.
- The average length of stay was below the England average for elective patients (3.8 days compared to 4.5 days) and slightly above the England average for emergency patients (8.9 days compared to 6.4 days).

Medical care (including older people's care)

- The medical services was consistently achieving the 18-week referral-to-treatment time target against the national target 90%. The compliance rate for geriatric medicine and neurology was 100% (April 2013 and February 2015)
- The trust met the 31-day cancer waiting time diagnosis-to-treatment target (April 2015 to June 2015) and the 62-day waiting time target from referral to treatment in (April and May 2015) although the target was not met in June 2015.
- The medical service had a higher number of cancelled operations on the day for non-clinical reason (July 2014 – June 2015). The overall average number cancelled per month was eight patients but figures ranged from 2 to 21 per month. The majority of patients were rebooked for operations or procedures within 28 days
- Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. Discharge coordinators supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS funded continuing care. Discharge arrangements were discussed at the daily board rounds.
- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged but are unable to leave the hospital due to external factors. The data provided by the trust demonstrated that between January 2015 to May 2015, there was an increasing number of delayed transfers of care.
- Staff told us that the main cause of delays was the provision of community services, especially care home placement, to meet patients' on-going needs. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall. Patients who had less complex need were assessed by in reach team from Southern Health NHS Foundation Trust who supported in facilitating discharges by providing short-term care support.
- In response to delayed discharges across the medical services the trust had designed 26 bedded Wykeham ward. Patients who were medically fit for discharge but were awaiting social care packages were transferred from care of elderly wards to Wykeham ward where patients would continue working on their rehabilitation goals. This had helped in creating capacity in care of elderly wards for patients who needed medical interventions.
- The trust had a discharge lounge where patients could await transport or final discharge arrangements such as medicines. The discharge lounge was open Monday to Friday between 8am and 6pm. Staff in the discharge lounge told us that patients could sometimes waited for up to two to three hours for medications to arrive. There were no patients in the discharge lounge at the time of our visit.

Meeting people's individual needs

- All patients over 75 years were screened for dementia using a recognised methodology on their admission. The patients living with dementia were assessed by the dementia specialist nurse who visited all the care of elderly wards and also saw referrals on the other medical wards. Staff had completed basic dementia awareness training. The wards we visited had a named dementia champion. The trust had developed a 'dementia care bundle' which assisted staff to meet the needs of these patients.
- There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.
- The trust had introduced a 'this is me' booklet for patients living with dementia, which had been developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. On the care of elderly wards we saw that patients living with dementia had this booklet and it was appropriately completed. A 'sunflower' symbol was used to identify people living with dementia on all of the care of elderly and medical wards.
- The trust had improved its performance against the national CQUIN dementia targets. The trust exceeded the target for 90% of patients over 75 years to be asked dementia case finding questions, and for patients to have a diagnostic assessment and be referred for further diagnostic advice. However, referrals for further advice were not consistently on target. (April 2014 – March 2015). The targets had been met from June 2014.
- There was an arrangement with the local NHS mental health services to provide a liaison service for people with learning disabilities and mental health disorders.

For example, a consultant psychiatrist who was employed by Southern Health Foundation NHS Trust visited the hospital to assess patients who were diagnosed with mental health disorders.

- Staff were able to access support from learning disability nurses, who were employed by Southern Health Foundation NHS Trust on week days for individual patients. The staff were not aware about any 'flagging' or 'alert' system being used when patients with a learning disability were admitted to the hospital. The learning disability nurses relied on the ward's staff or family members for individual referrals.
- The trust was supporting carers of patients with mental health problem to stay overnight if that was beneficial to the patients and if it was appropriate.
- Interpretation services were available and staff knew how to access the service when needed. A wide range of patients' literature was displayed in clinical area covering diseases. Procedure specific- information, health advice and general information relating to health and social care services was available locally. Patient information leaflets were not displayed in languages other than English.
- Every medical and care of elderly ward had activity coordinators who planned and conducted different activates for patients after consulting them. The activities included range of things such as arts and craft, music, dance, group lunches and movie time. We observed patients participating and enjoying these activities on care of elderly wards and stroke ward. Staff and patients' relatives told us this had helped in providing good emotional support, especially to patients living with dementia, and enabled them to feel the hospital was a homely environment**.**
- On Victoria ward there was a three bedded female bay which did not have washing or bathroom facilities. The female patients in this bay could only use the washing and bathroom facilities available in another female bay and had to walk across a male bay in order to access those. This was compromising patients' dignity as patients sometimes were in their night attire.

Learning from complaints and concerns

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

Medical care (including older people's care)

Are medical care services well-led?

Good

By well led, we mean that the leadership, management and governance of the organisation assure

the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

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

The strategy for the medical services was to provide a highly responsive service that delivered care as close to home as possible by providing medical services seven days a week on the two sites;Royal Hampshire County Hospital (RHCH) and Basingstoke and North Hampshire Hospital (BNHH) and at the critical treatment hospital (which the trust had planned to develop in near future).This was thought to be achievable with access to rapid diagnostics, a senior opinion and inpatient care when required.Staff we spoke with were aware of the strategy and described high quality patient care as key components of the trust's vision.

There was an effective governance structure to manage risk and quality. Staff felt

supported by their managers. There was strong local leadership on the medical and care of elderly wards. Staff said that the leadership and visibility of managers in medicine was good.

Staff were passionate to deliver quality care and an excellent patient experience. The culture was caring and supportive. Staff were actively engaged and there was a culture of innovation and learning.

Patient feedback was collected and used in planning many of the services we visited. These included patients' survey feedback and learning from complaints. 'Afternoon tea' session was held for patients and their relatives in the stroke wards. This gave patients an opportunity to share their experiences, and provided peer support and education. The session was also attended by a member of the stroke association team who delivered educational sessions related to care after stroke.

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

Vision and strategy for this service

- The service leads were clear about their priorities and had long term strategy for the medical services. The medical and care of elderly service leaders' long term strategy was based on the future plans of developing the 'critical treatment hospital' (CTH).
- The strategy was to provide a highly responsive service that delivers care as close to home as possible by providing medical services seven days a week on the two sites;RHCH and BNHH (and at the potantial site of CTH) with access to rapid diagnostics, a senior opinion and inpatient care when required.
- The leaders identified the priorities for the service to improve patients' journey and treating patients in the most appropriate area and specialism, developing frailty unit for care of elderly patients and to further improve and expand dementia care team for better care. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge especially for patients with long term conditions and complex frail elderly patients. We found some elements in the strategy that had been or were being implemented. For example; the trust had employed external consultants to assist in identifying challenges related to patients' journey and access and flow. The service was also aiming to improve the sustainability of seven day working across the three sites of the trust.
- Managers were able to discuss this strategy and describe the challenges the trust had in implementing it.
- Staff we spoke with were aware of the strategy and described high quality patient care as key components of the trust's vision. The staff we spoke to were passionate about improving services for patients and providing a high quality service.

Governance, risk management and quality measurement

- The medical services produced monthly performance and finance reports. It showed how the services performed against quality and performance targets.

Members of staff told us that these were discussed at team meetings and there were actions identified for targets that were not met. The ward areas had visible information in the form of the quality dashboard.

- The medical service had monthly clinical governance meetings where the results from clinical audits, incidents, complaints and patients' feedback were discussed and shared with staff. Minutes of clinical governance meetings showed patients' experience data were also reviewed and monitored.
- Within medical services, each medical speciality also had their monthly governance meeting, speciality performance meeting and also mortality and morbidity meetings. For example; the gastroenterology speciality had a monthly endoscopy user group meeting where the performance and other governance related issued were discussed.
- The clinical governance team collated data and produced a report for the service each month. Included in this report was a review of incidents, complaints, general patient safety information, infection control review, sharing from incidents and information. The medical services had a robust governance structure from ward level to the trust board.
- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. If staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The service had a risk register that included all known areas of risk identified in the medical service. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated. The higher risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee and risk committee.
- The medical services produced a monthly newsletter which was shared with staff. This included patient stories and lessons learnt.

Leadership of service

- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. Ward staff felt well supported by their ward manager, ward sisters and matrons and told us they could raise concerns with them.
- Staff in all the clinical areas across the medical services spoke highly about and had confidence in their local leaders, who included matrons, ward managers and lead consultants. Staff across medical wards told us matrons were visible and had a regular presence on their ward. Staff told us that the Chief Nurse was approachable and helpful.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.
- The student nurses told us they felt supported on the ward and received supervision training from the senior staff. They told us consultants were accessible and approachable.
- Staff told us the chief executive was visible within the trust and was approachable. All the staff spoke highly of the chief executive.
- Staff told us the medical service leads had a visual presence on the wards and provided good leadership.

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Culture within the service

- Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Medical, nursing and therapy staff felt that integration across medical services between RHCH and BNHH had improved in the last 18 months. Staff across the two sites attended several meetings and training sessions together and felt more engaged. Medical and therapy staff in some of the medical disciplines also worked across both sites. Staff felt this had allowed for improved coordination between the two hospitals and better management of patient care and treatment.
- Nursing staff highlighted that there were some inconsistencies with senior medical staff cover across the trust. The stroke team was highlighted team as an example of an integrated team in medical services.
- Frontline staff worked well together, and there was obvious respect between, not only the specialities, but across disciplines. Staff said they felt valued team

members. They provided examples where local management had supported them with their professional and personal development needs to enable them to work to their best ability.
- Staff felt proud to work for the trust. Staff, including student nurses, doctors and housekeeping spoke passionately about their work and of being part of the team. One senior nurse described the trust as a "personal place not just a face".

Public engagement

- There were examples of patients being closely involved in service development. These included patient survey feedback such as the NHS Friends and Family Test and learning from complaints and more proactive work to gather views direct from patients receiving treatment from different community services.
- 'Afternoon tea' sessions were held for patients and their relatives in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education. The session was also attended by a member of stroke association team who delivered educational sessions related to care after stroke. Patients were also given information about support available in the community.
- Clinical governance meetings showed patient experience data was reviewed and monitored.
- The CEO of the trust had an 'open door' policy. The staff across the medical services encouraged service users and their relatives to contact the CEO directly to express their views and suggestions about delivery and improvements of services in the ward.

Staff engagement

- The trust was taking initiative to engage and integrate staff across the trust's three main locations by creating different opportunities. Information was sent to staff regularly by email and the trust's monthly newsletter'. Staff were encouraged to look at the staff intranet. Band 7 staff had regular meetings across all t three hospitals which gave them opportunities to share practices and learn.
- Staff's views and experience were captured in the work that was being undertaken by external consultancy in improving access and flow for the patients in the hospital. Staff told us that made them feel valued because their views were listened to by the trust's management.
- The trust had developed a celebration award for staff which required peer nomination. Staff we spoke with were complimentary about this process. Information about the award was published on the trust's website on the intranet and within newsletters. Another award scheme to recognise staff was known as DONA (Director of Nursing Awards).Staff were proud to tell us about nominations for these awards.
- The junior doctors told us they were able to raise concerns and the trust conducted junior doctor forums where they could express their views and share new ideas.

Innovation, improvement and sustainability

- The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service. We saw examples of innovation and good practice which are noted below.
- The trust had introduced dementia volunteers who were members of public who received dementia training form the trust. They visited the care of elderly wards regularly and spent quality time with patients living with dementia by assisting them with various activities such as meal times, reading a newspaper or generally talking to them.
- Every medical and care of elderly ward had an activity coordinator who planned and conducted different activities for patients after consulting them. The activities included range of things such as arts and craft, music, dance, group lunches and movie time. We observed patients participating and enjoying these activities on care of elderly wards and stroke ward.
- The service leads acknowledged that cost improvement was becoming more difficult because the service growth figures were high because of the increase in the number of patients, especially unscheduled care. This had put a substantial financial challenge on the service. The service leaders were working collaboratively with financial partners and had identified a range of cost improvement plans (CIP).For example; the medical services had plans to hold an event to focus on exploring CIP-rich environment and process reviews. The service was working collaboratively with procurement, pharmacy, human resources and transformation team to maximise cross working synergies. The service had considered different areas where cost improvements could me made such as patient transport, electricity, use of agency staff and use of consumables.

Medical care (including older people's care)

- The service leads considered 'safety and quality' as a priority in the CIPs and had an approach 'spend money to earn money'. For example; the medical staff told us that they get a say on preferred consumables than cheapest consumables and the service was working closely with procurement on standardising consumables and making sure that the quality standards were met.
- The service leader also had a view that income target was a part of CIP. The medical services had opened a number of different services for patients such as the rapid access clinic, GP admission unit and was regularly meeting with CCGs to review and streamline the referral to treatment time targets (RTTs). The medical leads were committed to improving services despite a challenging financial climate.

Surgery

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

Information about the service

Royal Hampshire County Hospital provides emergency and elective surgery for a range of specialties. There are five surgical wards for trauma & orthopaedics (Bartlett Ward), general surgery (Kemp Welch Ward), planned major orthopaedic surgery (St Cross Ward), the colorectal unit (Wainwright Ward) and urology (Wykeham wards). There was also a short stay surgical ward and pre-assessment (Mount Ward). The hospital had five operating theatres.

The Winchester Treatment Centre at the hospital, had four theatres and three endoscopy theatres. The centre provides elective minor surgery (including Ear Nose and Throat (ENT), gynaecology, general, orthopaedic, colorectal urology, oral surgery, paediatric surgery) endoscopic procedures and ambulatory care.

Between January and December 2014, the Royal Hampshire County Hospital had 7,245 episodes of care. Of these, 27% were trauma and orthopaedic, 22% general surgery, 18% Ophthalmology and 34% other. The Winchester Treatment Centre had 6,503 episodes of care, Of these, 20% of which were trauma and orthopaedic, 13% general surgery, 43% Urology and 23% other.

During this inspection we visited 5 surgical wards, the operating theatres and post anaesthetic care area, and the treatment centre at the hospital. We spoke with approximately 22 patients, relatives/visitors and 36 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, therapists, pharmacist, pharmacy assistants and senior management.

We observed care and treatment and viewed 21 care and associated records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the hospital.

Surgery

Summary of findings

Surgery services were rated as 'requires improvement' for providing safe care and 'good' for being effective, caring, responsive and well led and

Procedures to ensure safe care required improvement.

There were not always adequate numbers of nursing staff to meet the assessed needs of patients, particularly at night on some wards. Resuscitation equipment and the storage of medicines in fridges needed to be appropriately checked in line with trust policy. Patient risks assessments for potential blood clots had not been done for patients within 48 hours of admission. The early warning score was not consistently being used to identify patients whose condition might deteriorate.

Incidents were reported and appropriately investigated and action plans were developed to improve staff learning and services. Compliance with the Five Steps to Safer Surgical checklist was 94% and there were actions plans to improve this. Surgical staffing levels were appropriate.

Care and treatment was provided based on national guidelines. The surgical directorate took part in a number of local and national audits and outcomes in surgery were similar to or better than the England average. Patients received appropriate pain relief and nutritional support.

There was good multi-disciplinary team working to centre care around patients. Staff had good access to training and received clinical supervision and annual appraisals. Seven day services were developing. Consultant led care was provided with 24 hour cover arrangements. Some multidisciplinary support was available form therapist for colorectal and orthopaedic patients over the weekend.

Patients were consented appropriately and correctly. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The surgical services provided care in a caring and compassionate way. Patients and their relatives told us staff understood their needs and treated them with sensitivity. Patients told us they were involved in their care and treatment and staff provided information in a way they could understand.

The hospital was achieving the referral to treatment time target of 18 weeks in some specialities; the target was not being achieved in orthopaedic and ophthalmology. Most patients who had their surgery cancelled on the day were rebooked for surgery within 28 days. The service was reviewing its capacity to identify ways in which service demands could be better managed

Support was available for patients living with dementia and patients with a learning disability. The service was taking part in a campaign in raising awareness and promoting better care for people living with dementia.

Complaints were handled in line with the trust's policy although many were not dealt with in a timely manner. Information about complaints was not displayed in ward areas

There were good leadership at all local level. Staff felt supported by the multi-disciplinary team, joint working and strong clinical leadership. Staff felt supported by managers who were considered to be visible, approachable and knowledgeable and were highly respected by their staff.

There was an effective governance structure to manage risk and quality. Staff were passionate to deliver quality care and an excellent patient experience.

The trust has continued to develop their engagement with patients including initiatives such as 'through your eyes' listening event', which was developed by the division and introduced across the trust. The service took part in research and national projects and innovative practice.

Surgery

Are surgery services safe?

Requires improvement

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

We rated safe as 'requires improvement'

There were not always adequate numbers of staff to meet the assessed needs of patients, particularly at night on some wards. There had not been an identified impact on patient care. Bank staff were used to cover shortfalls but staff were not always available and staff were working longer hours which was not sustainable. The trust was implementing actions to mitigate and reduce these risks. However, staff indicated that the escalation process could sometimes be unnecessarily lengthy.

Resuscitation equipment had not been appropriately checked in line with trust policy. Medicines stored in fridges had not been appropriately checked which meant the efficacy of drugs could be reduced.

Patient's risks assessments for potential blood clots but some had not been done for patients within 24 - 48 hours of admission. The early warning score was not consistently being used to identify patients whose condition might deteriorate.

Incidents were reported, staff were encouraged to report incidents and these were discussed at ward meetings and monthly quality meetings. Incidents were appropriately investigated and action plans were developed to improve staff learning and services. A safety thermometer was used on all the wards to monitor a number of risks including pressure ulcers, falls, infection control and the quality of care provided. The number of pressure ulcers was higher than expected. Action plans were developed to address shortfalls. Infection control practices were followed by hand hygiene rated needed to improve.

Medicines were stored securely and staff had the support of pharmacist to ensure patients had their medicines when they needed them. There was a robust process for the management of controlled medicines.

Records of care were available and these included care plans and risk assessments which were appropriately completed to inform staff's practice. Compliance with the Five Steps to Safer Surgical checklist was 94% and there were actions plans to improve this. Surgical staffing levels were appropriate.

Incidents

- Staff were aware of how to report incidents, through the use of the electronic recording system. Staff received training on using this system at ward level; it was not part of the mandatory training provided by the trust. Staff in general reported receiving feedback when they reported an incident. This was by email if they logged an incident or through discussion at team meetings.
- All incidents reported were analysed to ensure lessons were learnt. Staff in all surgical departments we visited told us they were informed about incidents, and discussed any changes to practice at team meetings. For example, following an increase in vancomycin resistant cases (VRE). A root cause analysis (RCA) was undertaken including observations of staff's practices and feedback provided. Action plan included screening of all patients on admission to critical care and appropriate measures put in place Basingstoke. The trust plan for this to start this from August 2015 across all sites.
- Monthly mortality and morbidity meetings were undertaken. Meetings minutes showed that a review of incidents was carried out. This included root causes analysis and discussion and any lessons learnt were shared.
- The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Most of the staff we spoke with did not have an understanding of the Duty of Candour. Staff told us they had not received training about this.

Safety thermometer

- The surgical wards undertook a monthly audit known as their "safety thermometer". This was an audit of the occurrence of avoidable harms, including new pressure ulcers, venous thromboembolism (VTE), catheter-related urinary tract infections (UTIs) and falls.

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms. Safety thermometer information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- During March 2014 to March 2015, the prevalence rate of pressure ulcers fluctuated but was falling. There had not been a consistent reduction in the prevalence rate of falls or catheter related urine infections and new urinary tract infections (UTIs) with periods of both reductions and then periods of increases.
- The surgical division performance and finance report (March 2014 – March 2015) identified approximately 30 falls per month although falls with moderate, severe harm or death was within expected numbers (overall below 3 per month). The number of hospital acquired grade 2, 3 or 4 pressure sores was overall two to three times higher per month than the expected target of 5 per month. The VTE risk assessment for 95% of patient was achieved in eight out of 13 months.
- Safety thermometer information was displayed at the entrance to the wards so that all staff and visitors were aware of the performance on the ward or department.
- Incidents of pressure ulcer, falls and catheter related infections were monitored and action plans developed to minimise risks of re occurrence. For example, one ward recorded information on patient falls and learning points from these incidents, which was then shared with staff. The ward reviewed the reason for each fall which occurred, to ensure there was not a regular reoccurrence of similar causes, to ensure learning had been implemented by staff.

Cleanliness, infection control and hygiene

- Surgical ward and theatre environments were visibly clean. Cleaning rotas were available on the wards; although they were not all fully collated.
- There were dedicated staff teams who were responsible for cleaning in the operating theatres, and regular checks and audits were completed
- Theatre staff were issued with "scrubs" for use within the theatre area and we noted staff adhered to infection control procedures.
- Staff followed infection control procedures including bare below elbow and used personal protective equipment when supporting patients with personal care.
- Hand sanitizer points were located at the entrance or close to each ward for visitors and staff to use, to reduce the spread of infections to patients. We found a number of hand sanitizers that were empty however; there were alternative points in the same corridor.
- We observed staff following hand hygiene procedures such as washing their hands and using sanitizing gels as part of infection control. However, hand hygiene audits for surgical services from March 2014- March2015 were between 92% (87- 97%). The target of 100% was not met.
- During the period of March –June 2015 there was no reported incident of methicillin resistant staph aureus (MRSA). There were two incidents of Clostridium Difficile (C .Diff) during that same period. There was a process for isolating patients and staff said they predominantly used the side rooms for any suspected cases until test results were received.
- Staff followed procedures for screening patients for MRSA pre-operatively or on admission if they were unplanned admissions. The incidence of MRSA was low within the trust. In March 2015 one case of community acquired MRSA bacteraemia was reported which was being investigated by the clinical care group.
- The trust had set their C. difficile trajectory for 2015-2016 at 34; they were at 16 at end June 2015. There were systems in place such as medical assessments to be completed within four hours of an outbreak.
- Microbiology laboratory had changed their process to inform the Bed Manager and Medical Registrar of all positive C. difficile tests out of hours in order for appropriate actions to be taken.
- There was an incidence of Norovirus at the trust in the period April - June 2015. This was an aggressive outbreak with rapid spread affecting both patients and staff. This was effectively managed with a multi-disciplinary approach which resulted in no ward closures.
- Surgical sites infection rates for total hip replacement was same as the national average at 1.2% for the months of January –March 2015. Isolation facility was used such as side rooms for suspected or infected patients.
- Infection control information was displayed on all wards. This included hand hygiene audit results and data on the number of cases of hospital acquired infection for the ward

- The Infection Control root cause analysis (RCA) panel was held on both the Basingstoke and Winchester hospital sites. Two panels a month were held to review any patient who had acquired a healthcare associated infection (HCAI).

Environment and equipment

- The oxygen and suction daily checklist had not been updated on C bay, on St Cross ward, for seven days of the current months recording sheet. There was a potential risk to patient safety should this equipment need to be used and then found to be faulty at the time of use.
- Resuscitation equipment was available on all the surgical wards and appropriate for use. There was a process within the service for the resuscitation equipment to be checked and recorded daily. This was not adhered to consistently. We found a number of occasions that checks of the resuscitation trolley had not been carried out in line with the trust internal procedure.
- The resuscitation trolleys were fitted with security tags and resuscitation guidance was attached to the trolley, to ensure staff had immediate access to current guidelines if needed, when responding to a patient in an emergency situation.
- Emergency equipment was available and there was a process for servicing of all equipment to ensure they remained fit for purpose. A random check of a number of equipment showed this was mostly adhered to.
- Patients who were assessed as at risk of pressure ulcers had appropriate equipment in place, such as pressure relieving mattresses. Staff carried out checks on these to ensure they remained in working order and fit for purpose.
- Random checks on pressure relieving equipment, fire safety and mobile hoists showed these had regular services completed and dates for the next service/ checks were recorded.
- All wards had hand sensor detector pads fitted, to enable access to and from the ward. These were fitted to protect patients who were confused and may leave the ward and come to harm. The doors on one ward were noted on two separate occasions to be open.

Medicines

- Medicines once opened had the date of opening recorded to ensure they were used within the timescale. On one ward we found open insulin vial had expired, which was used as stock. This was removed when we brought this to staff's attention during the inspection.
- Medicines were stored according to manufacturer's guidance and dedicated refrigerators were available for storage of some medicines as required. The temperature of medication fridges on the wards was monitored. However, this was not carried out daily and in line with the trust policy on the wards. Minimum and maximum temperature recordings were not done. This meant staff were not aware when the fridge temperature was either above or below the normal range. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients.
- On Bartlett ward, for example, the fridge contained supplements (fortified drinks and food) for patients' use. The temperature of this fridge varied between 10 and 19 degrees centigrade. The recommended temperature should be between 2 and 8. The contents may not have been fit for purpose.
- On Wainwright (eye) ward, the cupboard containing the eye drops, FP10 prescription pads and sick notes was found to be unlocked. The ward was not open on the day we visited and the ward door locked, so there was no immediate risk relating to access to the department. However, there was no assurance that this cupboard would normally be locked when the department was open.
- Medicines were stored securely with restricted access to the clinical rooms where these were kept.
- Dedicated pharmacy staff such as pharmacist and assistants was allocated to the wards. They undertook regular reviews of patients' medicines and provided staff with advice such as drug dosages and contraindications.
- The staff followed their internal procedure in the management of controlled medicines. They had a robust process for returning controlled drugs and detailed records were maintained.
- Wards we visited did not use the trust standardised recording form, which enables all relevant data to be captured, as required under the standard operating procedure for medication fridges.

- We observed a medicines round and staff were following guidelines on medicines administration and records of medicines administered were maintained. Patients said they received their medicines and doctors had discussed with them when they had been prescribed new medicines such as antibiotics.
- The lock on the treatment room door on St Cross ward was being repaired during our visit to the ward, to ensure medicines were stored securely at all times. This had been identified as a concern at a recent ward leader's meeting.

Records

- We reviewed 21 medical, nursing notes and other associated records as part of the inspection in terms of secure storage, access, quality and legibility of the records.
- The trust used a combination of paper and electronic system for patients' records. Access for electronic records was password protected and staff said this was secure.
- A standardised protocol was used for pre-operative assessments. Pre- operative assessments were completed and these records were available when patients were admitted. Staff said there were no problems in accessing assessments and medical records when patients were admitted for surgery. We found records were clear and legible.
- The storage of patient records was not consistent across all wards that we visited. Some wards kept notes in lockable trolleys, others in open trolleys by the nursing station. This allowed easier access to records for patients who were under the care of a multidisciplinary team.
- Staff on one ward raised concerns that the patients nursing records were recorded electronically, but medical notes used a paper based system. They felt medical staff did not always read the nursing record as the notes were not all in one place and easily accessible.
- Risk assessments such as pressure risks, falls and venous thromboembolism (VTE) were completed by nursing staff.
- The National Institute for Clinical Excellence (NICE, 2010) recommends that all patients should be **assessed** for the **risk** of developing thrombosis (blood clots) on a regular basis. A review of 27 VTE records showed these were completed except for those patients admitted within the last 24 to 48 hours. Where risks were identified preventative treatment was prescribed.
- The Five steps to safer surgery checklists (based on the WHO Surgical Safety Checklist) sets out five steps that should be undertaken during every procedure to help prevent errors. The guidance forms a basis from which organisations are able to adopt and adapt practice to reflect the needs of their service.
- Monthly documentation audits of the Five Steps to Safer Surgery checklist were undertaken and this was fed back at monthly team meetings. Whilst there had been an improvement against the completeness standards, for the first time this year, the surgical division had failed the standard to ensure the checklist was completed for all patients and documented in notes. Compliance with using the Five Steps to Safer Surgery checklist was audited in February 2015. The Overall compliance was 94% (94% for briefing; 86.5% sign in; 97% time out and 97% sign out). Some of the issues identified were of surgeons not participated or highlighting differences across the hospitals sites with time out procedures and anaesthetics practitioners to sign in for every patient. An action plan had been developed to improve practices.
- We reviewed patients' records in surgical wards and followed some of these patients through to theatres. Pre-assessments were detailed and theatre teams were using the Five Steps to Safer Surgery checklist which was an established process within the teams. We saw that information including the patient's identity, and known allergies and reactions were documented.

Safeguarding

- Staff on the wards, including non-clinical staff, were aware of what constituted abuse and the actions they would take and how to report issues to protect the safety of patients in vulnerable situations.
- Staff would report to the ward sister or matron and some were confident to report higher up if they felt action had not been taken or needed to be taken promptly.
- Staff were aware of the trust whistle-blowing and we were told they could find information on the trust's website.
- Medical, nursing and ancillary staff had attended safeguarding training. There were safeguarding policies

and guidelines for the protection of vulnerable adults and children. Safeguarding adults and children training was part of the trusts statutory and mandatory training programme.

- Seventy two percent of staff, within the surgical division, had completed safeguarding adults and children training, for the period April 2014 to March 2015, compared with the trust target of 80%.
- Surgical wards had safeguarding link nurse and specialist nurse to provide advice and support to patients and staff.

Mandatory training

- The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules .Staff told us they also undertook some on line training as part of their induction.
- Newly recruited medics had completed their trust's induction. They said it was useful; however they felt they would have benefited more from having more shadowing and less classroom teaching.
- Data provided by the trust indicated that in the last 12 months showed 80% of required staff had undertaken the local induction. Overall, 81% of staff in the surgical division had completed their statutory and mandatory training, for the period April 2014 to March 2015. Staff we spoke with reported they had sufficient time to complete their training.
- Staff took responsibility for booking their own statutory and mandatory training. A monthly training matrix was provided on each ward, so staff could see which training they needed to complete, to keep up-to-date.

Assessing and responding to patient risk

- The management of deteriorating patients was managed effectively. If a patient's condition deteriorated, nursing staff had an escalation process they followed to ensure prompt access to medical support. The surgical wards used the national early warning score (NEWS) to identify if a patient was deteriorating. However, NEWS records were not always fully completed on some wards where we found some gaps in documentation.
- We observed some handovers, these were well managed and occurred at shift changes with a multi-disciplinary team approach.
- Senior staff told us they often had a number of medical outliers on one of the surgical wards. Although they were reviewed during the week by the medical team; this did not occur routinely at the weekend due to medical availability. Patients, however, would be seen by the medical team if their condition deteriorated or an emergency.
- Risk assessments were undertaken on admission for risks of falls, malnutrition, venous thromboembolism, and pressure ulcers. Action plans were developed to manage the risks identified
- Patients identified as high risk of falls were monitored in bays close to the nursing station if possible and beds alarms were used to alert staff if patients who were at risk were getting out of bed so that assistance could be provided.
- There was a system of screening all surgical patients pre–operatively for risks of potential blood clots and appropriate therapy was prescribed according to risks. We saw that assessments had been completed and patients were prescribed appropriate therapy or preventative measures in all 11 the patients' records we checked.
- Compliance with using the Five Steps to Safer Surgery checklist was audited in February 2015. The Overall compliance was 94% (94% for briefing; 86.5% sign in; 97% time out and 97% sign out). Some of the issues identified were of surgeons not participated or highlighting differences across the hospitals sites with time out procedures.

Nursing staffing

- There are nationally defined minimum safe staffing levels for inpatient care wards. These include Safe Staffing: A Guide to Care Contact Time (NHS England, November 2014). Direct Care Measurements (NHS England, January 2015).
- Staffing numbers were identified based on the acuity tool used by the trust. Shifts were agreed in advance against the planned registered nurse to patient ratios required for each shift and these were rated Red Amber or Green (RAG) in terms of staff numbers. In all the wards

we visited, senior staff said staffing was reviewed regularly as there were constant changes and needing to move staff around. The actual staffing numbers were displayed in all the wards.

- The safer staffing data as published by NHS choices published between January - April 2015, the trust achieved 87-90% of registered nurses hours filled as planned. On night duty during the same period the trust had achieved 88-91% registered nurses hours were filled as planned.
- The national safer nursing care tool was used to plan nursing numbers for each ward. Audits were undertaken to assess percentage compliance with the planned nursing to patient ratio. This was captured for both the long day and night shift.
- In the surgical wards the staffing rotas showed that safe staffing levels (registered nurse to patient ratio) of 1:8 during the day were not always achieved. On several occasions the staffing levels were 1:13. The National Institute for Clinical Excellence (NICE 2014) reports that there was evidence of increased harm to patients when the ratio of registered nurse to patients was higher than 1:8 during day shifts.
- We reviewed the duty rota from one ward for one whole week in June 2015, the safe staffing levels at night was predominantly not achieved and was between 1:10 to1:13. Another ward had only two trained nurses on at night and no healthcare assistants. The ratio was 1:13. This meant staff could not leave the ward during their break time, in case their colleague needed support.
- Staff told us even when the staffing ratio was met; this did not always take into account the acuity of patients such as those requiring 1:1 care. Feedback from patients and their relatives included that the wards were always short of staff and response to calls bells were variable. Although the wards were "busy", patients were positive about the care and support they received in a timely manner.
- Staff on all wards raised concerns around meeting required staffing levels for all grades of nursing staff to ensure safe care of patients. Specific concerns included having the correct number of staff, but a number of staff were on working pattern restrictions, which made it difficult to provide cover for night shifts. Senior nursing staff carried the bleep and responded to calls concerning shifts which needed to be filled. Staff commented on difficulties filling shifts when staff called in sick at short notice and indicated that the escalation process through the division on staffing issues could be unnecessarily lengthy at times.
- Bank and agency staff were used to fill shift vacancies. A ward manager explained that the skill mix of staff was considered, between two neighbouring wards, when using agency staff, ensuring the correct mix of permanent and agency staff on each ward.
- The planned and actual staffing levels were displayed on noticeboards on each ward. On the day we inspected the wards, there were no shortfalls in planned staffing levels.
- Rotas for Wainwright (colorectal) for week of inspection and two weeks prior showed staffing matched the planned staffing for the ward.
- This Winchester Treatment Centre is staffed with a multi-flexible team of registered nurses, operating department practitioners and health care assistants. Staffing level was calculated according to the list and they used bank staff if extra support was needed. There were adequate staff with the right skills to provide care to patients. Information from lists, rotas and the staff confirmed the staffing ratio was usually 1:3 patients.
- The trust was aware of the staffing shortage and had put in place a number of initiatives to meet this demand. Agency and bank staff were used to fill the gaps. Although the trust put out regular requests for agency staff, the shifts were not always filled. They are also recruiting staff form overseas which were due to arrive by September 2015.
- The trust planned to make changes around the overall nursing structure by making the senior nursing staff ward based, and clinically focussed to help with staffing challenges and oversight of the ward.

Surgical staffing

- The surgical services were consultant led and they were available to support 24 hour care. Consultants worked throughout the week within the surgical services and were supported by specialist registrars during the weekends.
- The current medical staffing data showed there were 37% consultants, 9% middle career doctors, 39% registrars, and 11% junior doctors which was similar to the England average. Surgical consultants told us they

were staffed appropriately with the right skill mix. Junior doctors felt supported and told us that they could contact senior clinicians including surgical consultants if they required advice or guidance.

- Access to medical advice at night came from the hospital at-night team which was made up of nurse practitioners and junior medical staff. Staff said they were very responsive. Although the outreach team was not able to provide support as they were committed supporting patients in the recovery area which was not their principle role.
- In the treatment centre, there were always two anaesthetists for each paediatric list. This allowed them to deal with emergency issue such as airway spasm and for the safety of patients. Recovery nurses were all trained in paediatric resuscitation at level two and were supported from staff from the paediatric wards as needed.
- Handovers between teams occurred at the beginning of shifts. We observed handover between the receiver team and ward staff. This was carried out effectively and provided information about the patient's current condition and ongoing care. Staff said sufficient time was allocated for handovers for communicating important information and for staff to ask and respond to queries.

Major incident awareness and training

- The trust had developed a major incident contingency plan with a senior staff having designated responsibility for this.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were in place.
- Staff had received training in evacuation procedures and actions to take to deal with major incidents. Senior staff said there was an on call rota for such incidents.
- There was escalation system that dealt with bed pressures to ensure patients' needs were met when there was an increased demand on beds and winter pressures.

Are surgery services effective?

Good

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

We rated effective as ''Good.''

Care and treatment was provided based on national guidelines. The surgical directorate took part in a number of local and national audits. Patient outcomes overall in surgery were similar to or better than the England average, for example, patients sustaining fractures received appropriate care in a timely way. Therapists carried out thorough assessments of patients and developed plans of care to aid rehabilitation and recovery.

Patients received appropriate pain relief and nutritional support. Supplements were available for patients who had been identified as at risk of malnutrition. However patient's nutrition and hydration status was not always recorded. .

Staff undertook daily ward rounds five days a week and there was good multi-disciplinary team working to centre care around patients. Staff had good access to training and received clinical supervision and annual appraisals.

Seven day services were developing. Consultant led care was provided with 24 hour cover arrangements. Consultants were available for advice and support and an on call rota was followed. Some multidisciplinary support was available from therapist for colorectal and orthopaedic patients over the weekend.

Patients were consented appropriately and correctly. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Patients' needs were assessed and pre assessments were completed for elective surgery.

Evidence-based care and treatment

- National guidance and evidence based practice was being used. For example, staff followed practice guidance on the management of intravenous cannulas. Records contained venous infusion phlebitis (VIP)

scorecards which is a process of checking the cannula site. These were completed on the wards, although the records for some patients who had a cannula inserted in theatre were not always fully completed.

- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, and orthopaedics. These focused on adequate preparation at pre-assessment, covering pain relief and the management of fluids and diet, as part of post-operative recovery. For orthopaedic patients this also included exercises the patient could do post- surgery to aid their recovery. Therapists said they undertook home assessments to ensure any adaptation and equipment was available and ready for discharge.
- The occupational therapy team had introduced a questionnaire on assessment of the home environment, in response to changes on National Institute for Health and Care Excellence (NICE) guidance on falls: assessment and prevention of fall in older people
- The pre-assessment nursing staff followed a number of NICE guidelines and local policies to ensure patients had a thorough assessment and minimise the risk of complications during or after surgery. These included the recently introduced trust guidelines for pre-operative management of medicines in elective surgery patients, which incorporated relevant NICE guidance.
- Surgery staff undertook a number of audits such as pressure ulcer, surgical site infection, catheter related urine infection and falls. Action plans were developed and outcomes monitored.
- There was audit programme for surgery for the year 2014/15. Of the 93 projects identified across the trust, the hospital was involved in 41. The majority of audits did show completion dates as expected with action plans. Although 39% were overdue or abandoned. There was some evidence that learning from clinical audits was shared across the whole trust that included direct learning and transferable learning, where changes in practices could be transferred to other clinical areas and scenarios. Examples of audits completed at RHCH included IV fluid prescribing on the surgical wards and clinical variations in practice in laparoscopic cholecystectomy and surgical outcomes.

Pain relief

- Surgical patients had access to pain specialist nurses to provide support and pain advice as needed.
- Patients were positive about their pain management and information they had received at pre assessment. We observed staff assessing people's pain and offering pain control. The assessment was recorded in patient records.
- Patients on the colorectal ward, had access to support and advise from a specialist pain nurse.
- For patients living with dementia, who could not verbalise their level of pain, the Abbey Pain scale was used. Six observations were made and a score allocated to each one, giving a total pain score, which equated to a scale of no pain to severe pain. The patient's pain needs were then responded to and managed. Patients were positive about their pain control and they described different types of pain control they had received according to their pain severity.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. We observed that fluid balance charts were used to monitor patients' hydration status. However, MUST scores were not always reviewed post operatively which may impact on care and support people received.
- Patients had access to fluids including beverages. Patients who were at risk of malnutrition were prescribed supplements due to poor appetite. These were not always recorded on all five of the fluid balance records seen and staff could not be assured they had received these as prescribed.
- The patients said they were given choices for food and snacks. Patients were mostly satisfied with the meals provided. We observed staff were aware of patients who required extra support with meals and this was provided in a sensitive way.

Patient outcomes

- The mortality rate for surgical patients was within the expected range.
- The trust took part in a number of the national audits including emergency laparotomy audit, hip fracture and bowel cancer audits. The aim of the audits is to enable the improvement of the quality of care for patients through the provision of high quality comparative data from all providers.
- The number of patients admitted to Orthopaedic care within four hours was 43 % compared to England average of 48%.

Surgery

- The result from the national hip fracture database (NHFD) hip fracture audit 2014, showed patients 87% of patients receiving surgery on the day or after the day of admission compared with England average of 73%. This was down from 2013 when the trust achieved 93%. The hip fracture audit showed this service achieved 98% of patients who were assessed by an ortho-geriatrician during pre- operative assessment compared to England average of 51%.
- The bowel cancer audit 2014 results showed 92% of patients had their CT scan reported on which was higher than the England average of 89%. Those patients seen by a clinical nurse specialist was below the England average at 84%. Data showed 99% of these patients were discussed at MDT.
- The risk of readmission was above the England average for all elective surgery. The trust had set a target of 83 patients for 30 day readmission and between October 2014 and March 2015, this varied between 112-135 patients who were readmitted.
- The Surgical Site Infection Surveillance Service highlighted to the trust an increase in infection rates for total knee replacement between October and December 2014 compared to other trusts.
- Patients admitted for elective orthopaedic surgery, completed a patient reported outcome measures questionnaire (PROMS) prior to starting their treatment, so a comparison could be made before and after treatment had been completed. The trust scored similar to the England average for improvement following groin hernia repair, hip replacement and knee replacement surgery.

Competent staff

- The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules.
- Staff appraisal dates were displayed in staff rooms on wards. On one of the orthopaedic wards, 35% of staff had received an appraisal with the new ward manager, who had been in post for seven months. A quality issue had been identified, requiring a new appraisal to be undertaken with all staff, with the setting of clear objectives.
- The trust data on appraisal rates in general surgery showed 83% of nursing staff including healthcare assistants had completed an appraisal in 2014-2015.
- There was no formal process of nursing staff's supervision. Allied health professionals (AHP's) held monthly team study sessions, were staff, for example, could discuss complex cases. Staff also had an hour protected study time each week. Staff told us they could normally access this protected time. Junior AHP's also received monthly supervision.
- Medical staff attended mortality and morbidity meetings, where learning from complex cases was discussed and shared. A programme of talks relevant to the medical speciality was also offered.
- Junior staff told us they had regular training and protected time was allocated in order to achieve this.
- Therapy practitioners were supported through a programme of competencies to enable them to take on additional duties and support the physiotherapy team.
- Pre-assessment nursing staff had competed additional external training for their role, which included a period of supervision by the ward sister.
- The trust was developing the roles of healthcare assistants as part of their strategy for trained staff shortages.
- The GMC National Training Scheme Survey (2014) indicated the training given to junior doctors in surgery was similar to other trusts.

Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Surgical teams and nursing staff were involved in these together with physiotherapists and occupational therapists as required. We observed a good working relationship between theatre and ward staff during our visit.
- Doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards and other units.
- Patients' records showed they were referred, assessed and reviewed by multi-disciplinary team (MDT) such as dieticians, speech and language therapist and the pain management team when required.
- Pain specialist, and palliative care nurses undertook regular reviews of patients and most referrals were dealt with on the same day if possible.
- Medical support was accessed when required to support patients' medical needs.

- Pharmacy support was available served by pharmacist and assistants on wards and facilitated patients' discharges with take home medicines.
- The records viewed identified family involvement as necessary for effective discharge planning and referral to the community teams.
- There was evidence of good multidisciplinary team (MDT) working on the colorectal and the orthopaedic elective ward. MDT meetings were held on a weekly basis, to plan a continuing programme of care for long-stay patients. Therapy staff had a daily handover, linked with the medical team on some wards.
- There was access to a physiotherapy and occupational therapy area on one of the wards, providing patients with immediate access to rehabilitation and also enabling therapy staff to link directly with the nursing and medical staff caring for the patients. Therapists carried out thorough assessments of patients and developed plans of care to aid rehabilitation and recovery.
- Stomas nurses worked on the colorectal ward, working with nursing staff, who provided care for inpatients on the ward.

Seven-day services

- The surgical directorate provided consultant led care with 24 hours cover. Consultants worked throughout the week within the surgical services and were supported by specialist registrars. Consultants were available at weekends through their on call system.
- Consultants who were on call did not have an elective surgery list which meant they were available to deal with emergency including trauma cases.
- Access to medical advice at night came from the hospital at-night team which was made up of nurse practitioners and junior medical staff. Staff said they were very responsive and they could contact a consultant on call if needed and this was encouraged.
- There were no physiotherapy and occupational therapy service at the weekends. Therapists support was provided to patients on the colorectal and orthopaedic wards seven days a week. The weekend service was prioritised to patients with the greatest clinical need, for example, patients on the orthopaedic ward who had undergone surgery on the Friday.
- The pharmacy was open on Saturday and Sunday mornings. Outside of these hours, there was an on-call pharmacist to dispense urgent medications

Access to information

- Information at handovers was effectively shared, staff used an electronic handover sheet which provided up to date information about patients. Staff said this was very useful as they used this to record any changes. We observed some handovers and found information sharing was effective and staff had opportunity to ask questions.
- A discharge summary was sent patients' GP within 48 hours of a patient being discharged. This detailed the reason for admission and any investigation results, treatment and discharge medication. A copy of the discharge information was given to the patients.
- There was a good arrangement about working with GPs. A senior staff said GPS were able to access patients' records.
- There was a patient transfer summary in patients' notes for those who were transferred within the trust. These contained good details and staff said it assisted them in providing continuity of care.
- Staff told us the quality of information received from external providers and care homes were not always detailed enough and they often contacted care homes for more information. Although some care homes used the "this is me" document, this was not consistent for people who were living with dementia.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were followed to ensure decisions were made in the best interests of patients.
- Patients told us they had been provided with information regarding the surgery which they received with their booking confirmation letter.
- Patients were given explanations about the surgery and procedures had been given prior to signing the consent form. Patients were given opportunities to ask questions and were positive
- Wards had resource packs for DoLS and MCA to inform staff's practices.

- An application for DoLS had been made for a patient who lacked capacity, although they were awaiting approval from the local authority at the time of the inspection. Interim measures for management of this patient had not been developed in the absence of DoLS.
- Staff across surgery had completed their training on Mental Capacity Act and Deprivation of Liberty and Safeguarding.

Are surgery services caring?

Good

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

We rated caring as 'good'.

The surgical services provided care in a caring and compassionate way. This was clearly evidenced by the interactions observed between staff, patients and relatives. Patients and their relatives told us staff understood their needs and treated them with sensitivity. Feedback from national surveys found the service was similar to other trust and patients received expressed high degree of satisfaction with their care.

Patients told us they were involved in their care and treatment and staff provided information in a way they could understand. There was emotional support for patients, this included counselling support, for example for patients having amputations and hips and knee schools for patients having orthopaedic surgery to support their independence.

Compassionate care

- Patients told us the staff were responsive to their needs. Patients were complimentary about the care and treatment and said they were treated with respect; their privacy and dignity was respected.
- We observed care delivery on all the wards we visited, staff were compassionate and always treated patients with care and courtesy. Comments included "they do their very best". Relatives also echoed same sentiment and were grateful and "overwhelmed" by staff's kindness.
- A patient told us how the staff had made arrangements so they could spend time with their relative who was receiving end of life care in another area. They said they "felt very lucky to be able to stay" with their spouse and "it meant so much to me."
- The NHS Friends and Family test results were displayed on most wards. The results were displayed more visibly on some wards than others. The average response rate across all surgical wards was 37%, with a range of 27% to 59%, for the period March 2014 to February 2015. We saw posters encouraging patients to feedback their views, so wards could improve the care provided. Ninety six percent of patients who did respond would recommend the service to friends and family. This was in keeping with the England average of 95%. Monthly scores ranged from 93% to 98%.
- The CQC Inpatient Survey (2014) found the trust scored similar to other trusts on all the key indicators.
- Patients and relatives told us they received the support they needed to manage their treatment and hospital stay.
- Patient's comments were positive. This included statements such as the doctors were marvellous and staff supported them. Patients told us of reassurance they received over anxiety of having surgery and were prepared for their operation.
- We saw handovers were patients' focus and information was shared in a caring and compassionate manner.

Understanding and involvement of patients and those close to them

- Patients said they were able to speak with the consultant and other doctors caring for them and involved their family which they felt was important to them.
- They said all the staff and doctors provided them with information about the procedures and post-operative care. Where options had been available these had been discussed and patients had been able to seek clarification about their care.
- We observed nurses, doctors and therapists introducing themselves to patients, giving explanations and seeking consent prior to providing care.

Emotional support

- Patients had access to a chaplain. One patient told us they had received some support recently. They said "I am not regular churchgoer, but it was good the vicar was there if patients needed that support. Staff said they had access to other faith groups as required.
- Patients received appropriate support from staff and we observed staff providing reassurance to a confused person and this was done calmly with very good effect.
- A counselling service was available to patients through referrals from consultants managing their care for example on the vascular ward and patients undergoing limbs' amputation.
- The trust was undertaking hips and knee schools as a way of promoting patients independence and back to fitness programme.

Are surgery services responsive?

Good

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

We rated responsive as 'good'.

The service was reviewing its capacity to identify ways in which service demands could be better managed, there were changes planned for surgical admissions and developing greater efficiency for elective surgery.

Bed occupancy was above the national average of 88%. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. The service had surgical outliers on the gynaecology ward, these patients had been regularly assessed and followed by the surgical team.

The hospital was achieving the referral to treatment time target of 18 weeks in some specialities; the target was not being achieved in orthopaedic and ophthalmology. Most patients who had their surgery cancelled on the day were rebooked for surgery within 28 days.

Patients had access to written information regarding the type of surgery or treatment they had planned for and they received these in a timely way such as at the time the booking was completed. There was a variety of information leaflets and resources available although this information was only available in English. Support was available for patients living with dementia and patients with a learning disability. The service was taking part in a campaign in raising awareness and promoting better care for people living with dementia.

Complaints were handled in line with the trust's policy although many were not dealt with in a timely manner. Information about complaints was not displayed in ward areas.

Service planning and delivery to meet the needs of local people

- On the day of their surgery, patients having elective (planned) surgery were admitted to the relevant ward for the speciality they were being cared for by. One ward had an admission bay, which was used if all beds were taken in the main bays.
- Patients needing elective colorectal surgery had their pre-assessment and post-operative appointment on the ward. This enabled them to see the ward prior to their admission date.
- The Winchester Treatment Centre at the hospital is a day surgery unit at the hospital, which enabled patients to have minor surgery or procedures, without having a planned overnight stay in hospital. The trust planned an extension to the pre-operative and discharge lounge.
- The treatment centre also carried out a significant volume of paediatric work. Dedicated days were in place for paediatric lists. However as three theatres were in use there were times when children and adults shared the recovery areas. Staff said they tried to partition the bays to keep adults and children separate.
- There service did not currently have a surgical assessment unit and patients are accommodated in the medical assessment ward. There were plans to relocate this service in one of the bays on the surgical unit.
- The service had identified the need to additional clinics to increase capacity to manage referral and treatment times. An efficiency review had been undertaken by an external provider of the orthopaedics and ophthalmology services to identify ways to increase capacity to meet demands.

Access and flow

Surgery

- The bed occupancy was significantly higher than the national average of 88% (March 2014 – April 2015). The highest was seen at on Wainwright where they were 102% in April 2015. Bartlett ward had occupancy of 91%, Kemp welch was 94%. The lowest was at St Cross which was below the national average of 88%. It is generally accepted that bed occupancy above 85% level can start to affect the quality of care provided to patients, and the overall management of the hospital.
- Staff told us that the high the demands for surgical beds and emergency surgery had impacted on bed availability.
- Overall, the hospital had met the referral to treatment time (RTT) standard 92% to be on a list waiting for treatment for less than 18 weeks (incomplete pathway) from March 2014 – December 2014. The standard had not been met for January to March 2015. Orthopaedic surgery and ophthalmology were not meeting the target.
- The Department of Health (DOH) guidelines state that if patients require surgery and their operation is cancelled for non-clinical reasons, their operation should be re-arranged within 28 days. The trust had higher than expected number of cancellations for non-clinical reasons with approximately 19 patients per month being cancelled (March 2014 - March 2015). Only 13 patients (1 per month) had not been rebooked within 28 days.
- The average length of stay was similar to the England average but was longer for elective colorectal surgery and emergency trauma patients (January – December 2014).
- There were a number of surgical outliers being cared for on the gynaecology ward, at the time of the inspection. The staff from this ward told us that there was regular review of these patients by the relevant consultant and the care plan was clear.
- Day surgery patients were admitted at varying intervals during the day. This was in line with good practice guidance (British Association of Day Surgery, 2012) which recommends that there should be staggered admissions to limit fasting and waiting times. The service had appropriate discharge criteria.

Meeting people's individual needs

- Patients had access to written information regarding the type of operations or treatment they had planned for them. Information was sent to patients with booking information and some were available at the pre-assessment clinics. There were a variety of information pertaining to surgical procedures and maintaining healthy living and cessation of smoking. Patients and their family told us they were mostly provided with appropriate information in a timely manner.
- Some wards displayed additional information for patients, such as how to access support from the chaplaincy team; details on the supplies trolley, supporting patients who were not well enough or mobile enough to leave the ward. Free Wi-Fi internet access was provided for patients and visitors to use. Information was not available in different languages.
- There was a chaplaincy service available for people of all religious denominations; although staff were aware of the Church of England chaplain who visited. Facilities at the trust included a chapel, and multi faith room. The Chaplain was available out of hours and a senior staff said they could access religious representative from other religions if needed.
- Staff had access to dementia link nurses from the medical wards, and support from the mental health team and learning disability care teams as needed. Staff felt they were accessible and provided appropriate support.
- The trust had improved its performance against the national CQUIN dementia targets. The trust exceeded the target for 90% of patients over 75 years to be asked dementia case finding questions, and for patients to have a diagnostic assessment and be referred for further diagnostic advice. However, referrals for further advice were not consistently on target. (April 2014 – March 2015). The targets had been met from June 2014.
- There were dementia champions on the wards and the hospital used a sunflower symbol above a patient's bed to make staff aware of those patients living with dementia and the additional support they may need. The hospital also had a number of volunteers who spent time with patients living with dementia.
- The trust had recently introduced a new approach to identifying patient on a ward who was receiving palliative care. A discrete butterfly display at the nursing station highlighted this to staff. We saw this system being used on one of the wards we visited. Staff commented that this approach ensured they were aware of the patient and family's needs.

- Some of the wards we visited displayed information that they were taking part in ''John's campaign''. This is a national campaign promoting the right for carers to stay with people living with dementia when they are in hospital including outside the normal visiting hours.
- Access including those for patients with limited mobility was available and patients had a variety of equipment to support and maintain their independence. Bariatric equipment could be accessed with 24 hours from the equipment stores.
- All wards we visited provided care for patients in single sex accommodation bays, in line with Department of Health requirements. Side rooms were used, to ensure patients were not cared for in mixed sex bays. Toilets were not always clearly labelled if they were for male or female patients. Senior staff said they adhered to their policy for single sex accommodation and there had been no same sex breaches.

Learning from complaints and concerns

- There was limited information displayed on wards advising patients or carers how they could make a complaint. Information on how to complain was not available on all the wards we visited. Staff said they would direct patients to 'Patient Advisory Liaison Service (PALS)'.
- Patients were complimentary about their care and comments included "fantastic care and no complaints." They said they would speak to the ward sister if they had any concerns and were confident they would be listened to.
- The quality trust report for 2014-2015 showed as a result of the analysis of complaint data, bespoke training packages were developed to reflect the issues identified. They used specific examples from complaints and feedback and training had been delivered across the whole trust.
- Staff followed the trust's complaint policy and said they reported complaints from patients or their relatives to the manager.
- The trust was monitoring their response to complaints within 25 working days. The surgical division was responding to 59% of complaints on average within the trust target (January to March 2015).
- All patients who raised a complaint received a written apology from the chief executive officer (CEO). Contact information for the CEO was available on the trust's website to enable patients to raise their concerns.

Are surgery services well-led?

Good

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

We rated well-led as 'good'

The vision and strategy for the surgical division was primarily focused around the trusts plans for a new critical treatment hospital (CTH), with all emergency surgery taking place at the new hospital. Staff in general were aware of the plans for the CTH, but were unsure of the impact on their service. Consultants had raised concerns around how the proposed structure and did not feel their concerns had always been fully addressed by the senior management team

There were good leadership at trust and local level. Staff felt supported by the multi-disciplinary team, joint working and strong clinical leadership. Staff were confident about working with Basingstoke and North Hampshire and Andover hospitals and viewed this as a positive step. Staff felt supported by managers who were considered to be visible, approachable and knowledgeable and were highly respected by their staff.

There was an effective governance structure to manage risk and quality. Staff were passionate to deliver quality care and an excellent patient experience.

The services used patient feedback to develop. For example, the Patient engagement initiative such as 'through you eyes' listening event', which was developed by the division and introduced across the trust.

The service took part in research and national projects and innovative practice for the treatment of cancer patients. The division had introduced a number of changes to encourage cross-site working and to ensure consistency in the service provided to patients. This included changes to the rota system for consultant cover at the Basingstoke and Winchester sites.

Vision and strategy for this service

Surgery

- Ward managers we spoke to had a clear vision for their service. St Cross ward displayed their vision as part of their information for patients. Their vision was ''to provide the highest standard of patient centred care in a timely way and delivered with a smile''.
- The vision and strategy for the surgical division was primarily focused around the trust's plans for a new critical treatment hospital (CTH), with all emergency surgery taking place at the new hospital. The director of surgical services had a clear vision around how the surgical services would be distributed and effectively run between the new hospital. This was a focus on patient's medical needs and appropriate additional services such as rehabilitation.
- Staff in general were aware of the plans for the CTH, but were unsure of the impact on their service and where they would be required to work. Consultants raised concerns around how the proposed structure for their service would work and did not feel their concerns had always been fully addressed by the senior management team.
- Staff at all levels were passionate about improving the service for patients to ensure they provided a safe and effective service.
- The divisional leads also had oversight and strategy plans in place to improve services for patients currently, by addressing workforce challenges, efficiency issues and to improve and develop cross-site working across the current trust hospital locations.
- There was a strong emphasis on a consultant led-service, to achieve the best possible outcome for patients.
- Staff were anxious that there were fewer trauma specialities such as spinal surgery was no longer carried out at the service. There were concerns about the impact on staff as they may not choose to work at Winchester.

Governance, risk management and quality measurement

- Quality audits were used to seek assurance around patients' safety and identify areas for improvement. Audits included infection control, call bell response times and safety thermometer results. Audit results were displayed in staffrooms and discussed at team meetings.
- A divisional target had recently been agreed for review times for certain types of incidents, by the ward manager. For example, falls and pressure ulcers were to be reviewed within one week of the incident occurring, and staffing concerns within 30 days.
- There was a clear governance structure and process in place within the surgery division. The surgical services produced monthly performance and finance reports. It showed how the services performed against quality and performance targets. The ward areas had visible information in the form of the quality dashboard.
- Governance meetings took place on a monthly basis, which included monthly morbidity and mortality (MM), and reporting on finance, performance and quality issues within the division. Review of minutes from team meetings showed that learning from incidents was shared, audit, performance against referral to treatment time targets (RTT), and patient experience information.
- Once every two months staff took part in trauma audit meetings and joint meetings across the other hospitals were undertaken.
- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. If staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The service had a risk register that included all known areas of risk identified in the surgical service. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated. We did not see that higher risks (rated red) had been escalated to the trust's risk register.

Leadership of service

- There was a clear leadership structure in place within the division, led by the division medical director and operations director, with clinical directors for each speciality.
- Ward managers we spoke with felt well supported by their immediate manager and more senior managers within the surgical services division. They had access to training to enable them to undertake and develop in their role.

- Ward managers maintained a clinical component to their role, to ensure they were visible to staff and had an understanding of the demands of the service they were managing.
- There had been a number of changes to middle management staffing within the division, during the last year, due to staff undertaking secondments or acting up. Ward managers did not report any concerns despite the frequency of some changes.
- Staff of all grades spoke positively about the support from their immediate line managers and felt they could raise concerns.
- Ward managers felt there was a visible presence and support from the middle management team. They reported regular visits to their ward and felt the introduction of the 'daily huddle' had been beneficial.

Culture within the service

- Staff told us that team working was a particular strength at this hospital. They were developing strategies to encourage joint working which included nursing staff working at Basingstoke as part of their professional development
- Nursing staff told us their immediate manager operated an open door policy and worked on the ward as part of the team and were approachable.
- The trust's values about putting patients first were echoed by staff who were committed and passionate in providing "best care possible".
- Surgical staff told us there was a culture of quality improvement within the trust with regular meetings
- Staff said they felt management listened to their views such as staff's surveys. Staff valued the introduction of the WOW awards and DONA awards, where teams and individuals were acknowledged for the care, commitment and compassion they had shown. Wards and departments within the division displayed certificates for any nominations and awards they had won. The number of nominations was also reported on as part of the monthly quality report for each speciality and as part of the divisional monthly governance report.
- Staff spoke positively about the strength of the teamwork, but felt staffing pressures impacted on the quality of care they could provide for patients.

Public engagement

- One ward undertook an audit of the number of thank you cards received from patients and the comments they contained and this was shared with the staff. The service received a large number of compliments regarding the care they received
- Patients and carers were encouraged to provide feedback through the Friends and Family test. The division reported on the response rate as part the monthly scorecard. Between March 2014 and February 2015, the response rates to friend and family test across all surgery wards was 96%.
- Patients also participated in the 'through your eyes' listening event', which was developed by the division and introduced across the trust. Patients who had formally complained were invited to share their experiences of care with staff. An action plan was developed in response to the event and a copy shared with the patient.
- Members of the public could nominate a member of staff or a team for a WOW award.

Staff engagement

- Staff were aware of their whistleblowing policy. However, they said they did not feel able to use it as they had to report directly to their immediate managers before raising their concerns higher up. The staff said they would raise concerns higher up if necessary.
- Staff reported some positive outcomes from the staff survey such as excellent support form line managers, a good and caring organisation to work for, and generally staff felt feedback was used to improve services.
- Staff reported through the trust staff survey concerns around bullying and harassment and felt these were not being addressed properly. The division had developed a number of action points in response to this, including additional training for managers and development of greater support systems for staff.

Innovation, improvement and sustainability

- There were regular opportunities for staff to undertake secondments within the division to develop their clinical and leadership skills.
- As recruitment of experienced senior nurses was difficult, the trust has put forward development of junior staff such as orthopaedic diploma course.

Surgery

- A research project was being undertaken by one of the trust Registrar and Senior Clinical Fellow looking specifically oncoplastic and Patient Related Outcome Measures (PROMs)
- Through audit surgeons working have changed practise world-wide, such as the effect of biopsy on operable tumours. Other innovative practice included the need to wait for 6 weeks after completing chemotherapy before performing liver resection.
- A number of enhanced recovery programmes were in use across the surgery division, including in orthopaedics and colorectal. Patients were actively involved in all stages of their care from pre-assessment through to recovery. Patients were better prepared to cope when they returned home.
- The division had introduced a number of changes to encourage cross-site working and to ensure consistency in the service provided to patients. This included changes to the rota system for consultant cover at the Basingstoke and Winchester sites, so the set up was the same and the cover the same for a given number of patients. Within Urology newly appointed staff were required to work on both sites to develop consistent protocols and practices.
- Work had been completed with staff in the microbiology department to develop a 'surgi-honey' for the treatment of wound infection. This aids the healing process, by killing bacteria and boosting the body's ability to fight infection.
- There was a cost improvement programme (CIP) in place within the division. Sixteen areas had been identified for savings to be made, including patient transport, procurement costs and course fees. A new transport policy had been introduced in response to the CIP. There were more stringent guidelines for patients who could access patient transport services paid for by the trust.

Critical care

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

Information about the service

The Intensive Care Unit (ICU) at Royal Hampshire County Hospital (RHCH) has seven funded beds to provide care and treatment for critically ill patients. The beds are used flexibly to provide treatment for patients requiring level 2 or 3 care. Level two beds are for patients who require higher levels of care and more detailed observation and/or intervention. The patients may have a single failing organ system or require post-operative care. Level three beds are for patients who require advanced respiratory support alone or basic respiratory support together with support of at least two organs systems, This level includes complex patients requiring support for multi organ failure.

The management of critical care services for the Trust covers both the ICU at RHCH and at Basingstoke and North Hampshire Hospital (BNHH) and the High Dependency Unit (HDU) at BNHH, with some staff working across both sites.

Regional Paediatric intensive care services are provided at Southampton General Hospital. However, there are occasions when children are treated and cared for in the ICU at RHCH. In these incidences, a multidisciplinary approach, including discussions and guidance from the paediatric intensive care team at Southampton General Hospital and the involvement of a children's nurse to support the critical care nursing team, is used when treating the child.

There is no Critical Care Outreach Service at RHCH. Any outreach work is carried out by the critical care medical team when they have patients referred from the wards for critical care services.

During the inspection of Critical Care Services we visited the Intensive Care Unit. We talked with three patients, two relatives and 11 members of staff. These included nursing staff, student nurses, junior and senior doctors, physiotherapists, pharmacists, dieticians, housekeeping staff, technicians and managers. We observed care and treatment and looked at four care records. Before the inspection, we reviewed performance information from, and about, the hospital.

Critical care

Summary of findings

There were areas of good, outstanding and innovative practice in the critical care services. Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff. To promote the development of the nursing team the senior nursing team and clinical educator had taken the initiative to develop a critical care career pathway for grades 5, 6 and & 7. The nursing team was split into four teams. Each team had a team away day every two months during which they had time allocated to complete mandatory training. In response to difficulties recruiting middle grade (registrar) doctors the unit had developed a two year course in Advanced Critical Care Practice (ACCP), in conjunction with Southampton University. The ward manager's assistant had developed spread sheets that accurately monitored staff annual leave and mandatory training in a timely way and had introduced an automated text system to alert staff of shifts that needed filling. Innovative grab sheets on the unit that detailed required essential equipment needed to care for patients if the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.

There were effective risk management processes in place with processes to ensure learning from incidents was shared across the critical care units at both RHCH and BNHH.

Staffing levels and qualifications were in line with national guidance. This meant patients received care and treatment from staff who had the necessary specialist skills and experience.

Treatment and care followed current evidence-based guidelines with the exception of outreach services and critical care rehabilitation services. The risk to patients associated with not having these services was being monitored and action was being taken to try to introduce these services. The critical care services participated in national and local audits and there were good outcomes for patients. Staff had effective training, supervision and appraisal and there was good multidisciplinary working to ensure that patients' needs were met.

Data showed that outcomes for patients were comparable with those of similar critical care units.

There was strong leadership of the critical care service across the trust and in the unit at RHCH. There was a culture of mutual support and respect, with staff willing to help the unit at BNHH when they were short staffed. Innovative ideas and approaches to care were encouraged and supported.

Critical care

Are critical care services safe?

Good

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

We rated safe as 'good'

Processes and procedures were followed to report incidents and monitor risks. Staff confirmed they received feedback from reported incidents. There was a structured process to ensure learning from incidents was shared across the both the unit at RHCH and at BNHH.

Infection control practices were followed. There were low numbers of unit acquired infections, and the unit had not had an acquired MRSA infection since 2010.

The environment and equipment were well maintained. Action was taken when we identified that the resuscitation equipment trolley was not locked.

There was effective management of medicines, prescribing was electronic. Medicines were stored in secure areas. Action was taken when we identified that the medicine container holding medicines required during the transfer of patients was not secured to the transfer trolley.

Records were current, clearly laid out and provided a clear record of patients care and treatment. Safeguarding procedures were followed to protect vulnerable adults from abusive situations.

The trust set a target of 80% compliance for all staff with mandatory and essential training, generally this target was met

Outreach services to assess deteriorating patients in the general hospital were provided by critical care medical staff. Audits and monitoring of this had identified the need for a formal critical care outreach service, which was being actioned.

Staffing levels met patient's' needs. Both nursing and medical staff levels were in line with relevant national guidance. However, at times when the unit was quiet nursing staff were sometimes deployed to assist elsewhere in the hospital. This sometimes caused problems when a patient was being admitted to the unit and the critical care nurse could not get released from the general wards. The service was monitoring the frequency these events occurred and the impact it had on patient care and treatment.

Staff knew where to access major incident plans, should they be needed. Innovative grab sheets on the unit that detailed required essential equipment needed to care for patients if the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.

Incidents

- All staff in the critical care department that we spoke with knew how to escalate and report incidents. They knew they needed to report incidents such as patient falls, equipment errors, medicine errors, admissions and discharges to and from the unit out of hours (between the hours of 10pm and 7am). Staff reported they received feedback that incident reports had been received.
- Incidents were reported using an electronic reporting system. Staff reported that it was easy and quick to use.
- We reviewed reported incidents for the period April to June 2015 during which time 26 incidents were reported. The records showed there was a culture of reporting all incidents, reviewing and investigating incidents and taking action where required to reduce the risk of similar incidents occurring. An increase in pressure ulcers from non-invasive ventilation face masks had been identified from incident reports. Action taken had included liaising with other critical care services to find out what action they took to reduce risk of facial pressure ulcers and implementing the use of alternate facial mask equipment. Changes to the way in which controlled medicines were checked were made in response to a number of record management incidents relating to checking of controlled medicines. In both cases the number of recorded incidents had reduced since the implementation of new practise. The incidents and learning were shared across both the critical care units of the trust.
- Records of nursing staff meetings and critical care governance meetings showed that learning from incidents was shared across critical care services in the trust, as well as learning occurring from incidents that

occurred across the local critical care network. Examples of actions taken in response to incidents included a band 6 project work that looked at how to reduce the incident of pressure ulcers from facial masks, which included trialling alternative masks.

- The practice of mortality and morbidity meetings was embedded into the running of the unit. (Mortality and morbidity meetings are peer reviews of the care and treatment of patients with the objective to learn from complications and errors and to prevent repetition of any errors leading to complications). Meetings were held monthly and were attended by the multidisciplinary team. Nursing staff confirmed they attended the meetings along with the medical staff. Records of the last three mortality and morbidity meetings showed that the treatment and care practices for the patients was critically reviewed, and where appropriate proposed changes of practices were identified. This included liaison with other departments such as the wards and the emergency department to improve care and treatment of patients.
- Staff understanding about the Duty of Candour legislation was variable. Junior staff, both nursing and medical, understood Duty of Candour to mean they had to be open and honest with patients and their relatives. Senior nursing and medical staff understood their responsibilities with regard to the Duty of Candour legislation. The electronic incident reporting system had prompts to remind staff to inform the patient/ relative/ carer of the incident and to record the conversation in order to support them with the Duty of Candour process.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls.
- The unit followed the trust wide process for reporting safety thermometer information.
- Safety thermometer information was displayed at the entrance to the unit. For April, May and June 2015 the information showed no incidents of new pressure ulcers, catheter related urinary tract infections, venous thromboembolism and falls, In July 215 there was one incident of a pressure ulcer that had not been acquired on the unit and one incident of a urinary tract infection that was acquired prior to admission to the unit.

Cleanliness, infection control and hygiene

- Following the trust's policy, all patients were screened for MRSA on admission to the unit, treated prophylactically and rescreened five days later.
- Data from the Intensive Care National Audit and Research Centre (ICNARC) detailed that rates of unit acquired MRSA and blood borne infections were less than those of similar critical care units. For the period April 2010 to March 2015 there had been no unit acquired MRSA. The rate for Clostridium difficile infections was similar to that of similar critical care units. (Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.)
- The unit was visibly clean at the time of inspection. 'I am clean' stickers were used to identify when equipment was last cleaned.
- Cleaning staff were visible at all times of the inspection. We observed that as soon a patient vacated a bed space cleaning staff immediately cleaned that area. Cleaning schedules were on display throughout the unit. Check lists and audits were completed evidencing cleaning was completed to the required standard and in line with the schedule.
- One patient described how staff clearly explained the infection control processes to their young child who was visiting them.
- Personal protective equipment, such as gloves, aprons and glasses, were available. We saw staff used this equipment when providing patient care and treatment, and disposed of the equipment after they had completed the episode of care.
- Different coloured aprons were used for each bed space; this meant it could be easily identified if staff did not change aprons between caring for different patients.
- The unit had two side rooms, one of which had a lobby and airflow system to help prevent the spread of air borne organisms.
- Hand cleaning facilities, including hand gels were available at the entrance to the unit and throughout the unit. Staff complied with the trust's policy of bare below elbows. We observed staff challenging visiting professionals if they did not remove watches or roll their sleeves up.

- There was a unit infection control team that included medical and nursing staff, to support staff with infection control practice.
- It was observed during the inspection that engineers were running the water from the water taps to reduce risk of water borne infections.
- There were no dates for when disposable curtains were changed. The trust policy was that curtains were routinely changed every three months with the date of the next required change recorded on the curtain. This was the responsibility of the housekeeping staff. However, no dates were recorded on the curtains. This was raised with the trust, who confirmed that housekeeping staff had been unaware this was their responsibility. Action was taken, which included housekeeping staff being informed of their responsibility and health care assistants keeping a diary record of when curtains were changed and needed to be changed. We were told that curtains were changed after an infected patient was moved from the bed area.
- There was microbiology involvement on the ward rounds to assist with management and treatment of infections, including appropriate use of antibacterial medicines. Patient records evidenced involvement of the microbiology team.
- Monthly infection and preventing audits assessed compliance with policies for hand hygiene, insertion of venous cannulas and urinary catheters and the on-going care of venous cannulae and urinary catheters. Where the unit did not score 100% compliance the reason way and action taken were recorded. Compliance with the above in the period April 2015 to July 2015 ranged from 50% to 100%. Most of the noncompliance related to lack of documentation to evidence appropriate infection control practices were being followed, rather than poor clinical practice.
- Comprehensive annual infection prevention audits of the unit's environment were carried out. The last audit was completed in February 2015. The report from this audit showed an overall compliance rate of 92% with the infection and prevention policies. Areas of concern were noted with some aspects of the cleanliness of the environment and an action was put in place and followed to improve standards in this area.

Environment and equipment

- The unit was secure and access was by electronic swipe cards that were only issued to staff who had authority to enter the critical care unit. Visitors entered the unit by a door bell and intercom system. Unit staff welcomed each visitor individually.
- Resuscitation equipment, that included equipment for the management of airways, was available on the unit. Records showed the resuscitation equipment should be checked daily. However, there were some missing entries to evidence the equipment was consistently checked daily. The trolley that held the resuscitation equipment was not locked. This, and the lack of evidence of consistent daily checks, posed a risk that if a member of staff removed a piece of equipment without replacing it, this would not be identified and the trolley would be missing essential equipment in the event of an emergency situation occurring. This issue was raised with the Critical Care management team who took immediate steps to assess the risk of this situation and take any appropriate action to reduce any risk identified.
- There was a transfer trolley that contained equipment to transfer critically ill patients between departments and between hospitals. Daily equipment checks were completed for this trolley.
- Staff said that essential equipment was always well stocked, with individual patient bedside trolleys being filled up each shift. The hospital had an equipment library that the unit could access at all times to get equipment.
- We saw on visual inspection, medical equipment, including mechanical ventilators, renal replacement machines, infusion and feed pumps were cleaned, serviceable and when not in use stored correctly, they were all in date for servicing and PAT testing.
- The critical care service had a dedicated critical care equipment technician working across both RHCH and BNHH, who supported staff with the maintenance and availability of equipment.

Medicines

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

- Medicines were stored in secure areas. Medicine preparation rooms were secure, with members of the public not being able to access the rooms. Access was gained to these rooms via an electronic swipe card that was only activated to nursing staff and pharmacy staff who worked on the unit. Controlled medicines were stored in a locked cupboard that complied with the trust's policies. The keys to access the controlled medicines were held by the shift team leader, in order to minimise confusion as to where they were. Medicine fridges were kept within cold storage limits and a register of these were kept daily.
- However, the transfer trolley had a medicine container holding medicines required during the transfer of patients that was not secured to the trolley or a wall. This meant there was a risk that the medicine container could be removed from the trolley without anybody's knowledge. There was no assessment of the risk of the medicine container being removed and therefore not available when needed. This issue was raised with the Critical Care management team, who took immediate steps to assess the risk of this situation and take any appropriate action to reduce any risk identified.
- Nursing staff said they received training about the safe administration of medicines and could only administer medicines after they had completed competency assessments.
- Electronic prescribing was practiced on the unit. Changes made to prescriptions were routinely checked by the pharmacist to ensure the medicines were prescribed correctly and were appropriate for the patient. There was an allocated pharmacist who provided support for the unit.

Records

- Records were current, clearly laid out and provided a clear record of patients care and treatment. The majority of patient records were paper records. However admission details and assessments for the risk of developing venous thromboembolism (VTE) were also recorded electronically.
- There was a uniform process for daily recording of both nursing, medical notes and patient observation across the critical care units at both hospitals. Observation charts were located at the patient bedside. Observation charts recorded detail of medical plans/instructions for the forthcoming 24 hours, multidisciplinary input, such as physiotherapy and dietetic input and brief detail of conversations had with patients and their family or relevant others.
- Staff said since the form had been introduced they found the fact that all essential information and instructions were in one document enhanced the safety of patients as there was no risk of staff not seeing the information. More detailed medical information was recorded in the medical notes; this included detailed information about discussions with patients, families and treatment decision making processes.
- However the form was large and some staff said they found it 'cumbersome' to use. Staff said there was a plan to review and revise the charts, but there was no date yet for that review.
- Nursing records included risks to the patient of development of pressure ulcers, malnutrition, venous thromboembolism and specific risks that were associated with their clinical condition. Where risks were identified detail was included in their care plan about the action required to reduce the risk to the patient.
- The ward manager's assistant had responsibility for maintaining a spreadsheet detailing the nursing staff compliance with mandatory training. They explained there was a delay from staff completing mandatory training to the trust updating their records. This meant trust records did not consistently reflect the current compliance rate for mandatory training.

Safeguarding

- Safeguarding children and safeguarding adult's information files were accessible in the unit and staff knew where to access them. Staff told us information about safeguarding both children and adults was also accessible on the trust's intranet. Both sources of information provided detail about who to contact if staff suspected a patient was at risk or had been exposed to abuse.
- Training records provided by the trust showed compliance with mandatory training across the trust about safeguarding adults and children in January 2015 was at 72%. This was below the target of 90% compliance.
- In conversations staff demonstrated an awareness of safeguarding procedures and how to recognise if a patient was at risk or had been exposed to abuse.

Critical care

Mandatory training

- The trust reported that mandatory and statutory training covered basic life support, conflict resolution, counter fraud, equality and diversity, fire safety, health and safety, infection control, information governance, manual handling, safeguarding adults, safeguarding children and corporate trust induction.
- Training records provided by the trust showed that compliance with mandatory training for nursing staff on the unit was above the target of 80% for most subject areas with exception of basic Life Support which was at 74.65%, infection control which was at 76%. Medical staff only achieved the 80% compliance with conflict resolution, health and safety, and safeguarding adults and children.
- All staff confirmed they had time provided for mandatory training. The nursing team was split into four teams. The unit had introduced a practice where each team had an away day every two months during which they had time allocated to complete mandatory training.

Assessing and responding to patient risk

- A nationally recognised early warning system (EWS) was used was used on the general wards to monitor patient's health and identify patients whose health was deteriorating. Policies were in place that detailed when assistance should be sought from medical staff. However it had been identified by the service that despite the policy being in place the unit received referrals for critical care that were not appropriate or that were not made in a timely manner. Records of Mortality and Morbidity meetings detailed incidents where they had been delayed or inappropriate referrals to the critical care team. One example was detailed in the meeting of 21 May 2015, where a patient waited six hours in a deteriorating condition prior to a referral being made to the critical care team. To address this issue the EWS chart had been revised to clarify when the critical care team needed to be alerted to a concern.
- The critical care service had completed an audit to identity the frequency of out of hours inappropriate referrals in the period November to December 2014. This identified that for the 35 referrals made in this time scale, 29.5% of these were inappropriate referrals. The reasons for the inappropriate referrals were identified as junior medical staff not understanding referral criteria for critical care patients, and a lack of escalation plans for medical patients. The findings were shared with the general medical teams and a re-audit was planned for October 2015 to identify whether improvements had been made and if any further action was required.
- The trust's National Adult Early Warning Score Policy authorised April 2013, due for review April 2016, stated "The Critical Care Outreach team are responsible for attending NEWS calls within outreach hours and supporting ward nurses and junior doctors to put appropriate plans of care in place, providing specialist advice and treatments as necessary." However, at RHCH there was no outreach team to provide this support. Records of Governance and Mortality and Morbidity meetings indicated recognition of the need to have an outreach team at RHCH. In the operation/governance meeting dated 21 May 2015 a summary of incidents for five delayed admissions to the critical care unit identified the need for an outreach service to support staff on the wards in providing care for critically ill patents whilst waiting for beds on the unit. It was detailed that there were "still no recruitable applicants for RHCH" At the time of the inspection medical staff working in the critical care department provided advice and support for staff on the wards in providing care for critically ill patients whilst waiting for beds on the unit.

Nursing staffing

- Staff reported that staffing numbers were sufficient to ensure staffing numbers were in line with the recommended guidelines. Level 3 patients were nursed on a one to one ratio and level 2 patients were nursed on a two patients to one nurse ratio.
- Daily planned and actual staffing numbers were displayed on the unit. However, the proforma for displaying these figures did not fit with the fluctuating needs and dependencies of patients in the critical care setting.
- Gaps in the duty rota caused due to staff absence or vacant posts were covered by staff in house or staff form BNHH. This meant there was generally no use of agency staff, which meant the unit met the national guidance that no more than 20% of the work force on any shift should be agency nursing staff. In June 2015 there were no agency nurses used.
- A telephone text system had been successfully introduced by the ward manager's assistant to give staff more flexibility to adjust their shifts and to be offered

additional duties to backfill shortfalls at periods of reduced staffing, or high service needs. Staff said they liked this system as it allowed greater flexibility for home and work life balance and greater scope to alter their shifts at short notice.

- The core standards detailed the number of supernumerary clinical coordinators required to be on duty each shift, depending on the number of beds in a unit. The unit consistently met the standard of having one clinical coordinator in charge of the shift if there were more than six patients on the unit.
- Staff expressed concerns that when the unit was quiet they were sometimes asked to help wards/departments elsewhere in the hospital. This was done on the understanding that if a critically ill patient needed to be admitted to the unit, the nurse would be released to return to the unit. However this did not always happen, leaving the critical care unit understaffed. All such incidents were raised at Divisional performance meetings and were reported on the trust's electronic incident reporting system. The service had started monitoring the frequency of these events occurring.
- Patients and relatives we had conversations with expressed the opinion there were always sufficient numbers of staff available to attend to their needs.
- The unit employed research nurses who were funded by the National Institute for Health Research to carry out research activities as well as employing an audit nurse responsible for collating data to provide to ICNARC.

Medical staffing

- Medical staffing on the unit met the Guidelines for the Provision of Intensive Care Services (2015) for ensuring critical care units had appropriate numbers of medical staff on duty with appropriate qualifications and experience at all times.
- Recruitment to the consultant intensivist rota meant the service met the national guidance that detailed the consultant patient ratio must not exceed a range of 1:15.
- Numbers of resident medical staff meant the service met national guidelines that detail the ICU resident/patient ratio should not exceed 1:8.
- Junior doctors working on the unit confirmed there was always sufficient senior medical staff on duty.
- In line with national guidelines critical care consultant ward rounds occurred twice a day seven days a week, evidenced by conversations with nursing and medical staff and viewing patient records.
- In line with national guidelines a consultant intensivist was always immediately available 24 hours a day, and when not on the unit able to attend within 30 minutes.
- In line with current practice across the country, short falls in the number of trainee medical staff were being filled with Advanced Critical Care Practitioners (ACCPs).

Major incident awareness and training

- A major incident policy and business continuity plan was easily accessible in paper format and on the intranet. Staff knew where to locate the plans. There were action cards detailing the role and responsibilities for different grades of staff. This plan was in the process of being reviewed. We reviewed the draft which included updated action cards, including action cards detailing the responsibilities of the critical care consultant in charge; however this had yet to be completed.
- There was an innovative practice of grab sheets on the unit that detailed required essential equipment needed to care for patients if the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as pottering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.

Are critical care services effective?

Good

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

We rated effective as 'good'

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

Nursing staff numbers met the nationally recommended quota of 50% having a qualification in critical care nursing, which meant patients received care from nursing staff who

had relevant specialised skills. There was a dedicated nurse educator, who was supported by a part time nurse educator. All staff had to complete competencies in critical are nursing. The development plan for education for critical care nursing staff was developed across both sites. This meant staff at both sites had the same training and education opportunities. Medical staff confirmed they had training opportunities. Junior medical staff spoke positively about the support and training they received. However some expressed dissatisfaction with the fact they sometimes had to take holiday leave to attend essential training.

Multidisciplinary working was evident and staff were very proud to be part of the multidisciplinary team.

Staff had a good understanding of the Mental Capacity Act 2005 and how it related to their working practices. There was evidence that both formal and informal consent were obtained, and that best interest decision-making processes were taking place. However, we observed one incident when staff on the unit were reluctant to challenge the manner a surgeon was presuming a patient did not have capacity to consent to surgery.

Evidence-based care and treatment

- The critical care unit's care practices followed current evidence based guidance. We observed a medical handover during which the conversation showed that evidence based treatment was carried out.
- Nationally recognised care bundles were followed, this included care bundles to reduce the risk of ventilator acquired infections and central line infections and complications.
- The lack of critical care rehabilitation follow up services for patients meant the service was not following the NICE CG 86 guidance which details patients discharged from critical care settings should have access to critical care follow-up clinic.
- Critical care services took part in a number of national audits to measure the effectiveness of care and treatment provided. Some of these audits included data submitted to the Intensive Care National Audit and Research Centre (ICNARC) and the National Cardiac Arrest Audit.
- There was a research/audit board in the unit displaying current open trials
- There was audit programme for critical care services for the year 2014/15. Of the 20 projects identified across the trust's critical care service, the hospital was involved in seven. The majority of audits did not show completion dates as expected. There was, however, evidence that learning from clinical audits was shared across the whole trust that included direct learning and transferable learning, where changes in practices could be transferred to other clinical areas and scenarios. Examples of audits completed at RHCH included overnight referrals to ITU. The audit had been completed with an action plan for improvements.

Pain relief

- We saw patients' pain and response to pain relief was monitored and recorded on their daily charts their as part of their routine observations. Patients and their relatives said their pain was well controlled.
- During ward rounds, the pain-relieving needs of each patient were discussed and their pain-relieving medication adjusted accordingly.
- Patients who we could have conversations with, said their pain was well controlled and nurses gave them pain relieving medicines when they needed it.
- Conversations with staff evidenced they assessed patients' pain levels by observing non-verbal signs, such as facial expressions, as well as listening to patients who were able to express their level of pain.

Nutrition and hydration

- All patients had assessments completed about their nutritional and hydration needs, and their risk of malnutrition. Protocols and policies were in place regarding enteral and parental feeding practice.
- In line with national guidance the unit had a dedicated dietician to support patients with meeting their nutritional needs. One patient we spoke with spoke highly about the support they were receiving from the dietician in relation to meeting their nutritional needs and wishes. The patient said the dietician was going "above and beyond" her role in sourcing specific flavoured soups they liked.
- Speech and language therapists were available to check that patients were safe to swallow, and to offer advice accordingly if patients did not have a safe swallow reflex. Instructions from speech and language therapists were recorded in patients' records and care plans. Four

nurses on the unit had completed training in order to assess patients with swallowing problems and implement safe feeding programmes if the speech and language therapist was not immediately available.
- We observed staff supporting patients to eat in a sensitive manner. Patients, where able, sat out or sat up in bed to have their meals.
- Nutrition and hydration was monitored on the patient's daily charts.

Patient outcomes

- The unit submitted data to ICNARC in order to monitor patient outcomes and compare performance to that of similar units. The most recently published report was viewed, which was for the period 1January 2014 to 27 June 2014.
- The data showed that mortality rates were similar to those of comparable critical care units.
- Data for unplanned readmission to the unit within 48 hours showed the unit was performing at a similar rate to other similar critical care units.
- ICNARC data showed the MRSA, and blood borne infections were lower (better) than those of similar units. There had been no reported cases of unit acquired MRSA since 2010.
- The same data collection showed the unit was similar in performance with regard to delayed and out of hours discharges as other comparable units.

Competent staff

- 67 % of staff had completed further specialist training in critical care nursing. This met the national guidelines that a minimum of 50% of nursing staff in a critical care setting should have a post registration qualification in critical care nursing. This meant patients were cared for by nurses that had specialist training and skills.
- All nurses newly appointed to the critical care unit had a six week supernumerary induction programme. Staff confirmed they remained supernumerary throughout this period. The supernumerary period could be extended if both the nurse and their mentor felt it was needed.
- There was a recently appointed nurse educator for the unit. There was no nurse educator at BNHH. This meant the nurse educator at RHCH was supporting nursing staff at both sites unit a nurse educator was recruited for BNHH. There was also a band 6 nurse at RHCH who had the role of nurse educator for one day per week. Staff spoke positively about the support and training opportunities provided by the nurse educators.
- Nursing staff confirmed they receive annual appraisals. Data provided by the trust showed that in the month June 2015 the appraisal rate for staff was 87%. Nursing staff confirmed they had regular one to one clinical supervision session with their mentor or the clinical educator, which supported them to develop their skills and competencies.
- All nursing staff completed National Education Competencies in Critical Care.
- Revalidation of nurse registration had commenced.
- Junior doctors confirmed they received appropriate training and support at all times when working on the unit. However, some junior doctors expressed dissatisfaction that they had to take holiday leave to attend some essential training. However, the GMC National Training Survey for 2015 results did not identify any dissatisfaction with medical staff training in critical care services.
- To promote the development of the nursing team the senior nursing team and clinical educator had taken the initiative to develop a critical care career pathway for grades 5, 6 and &7. This included desirable and essential skills they should be achieving at 0-6 months in post, 6 – 15 months in post and post 15 months in post. The programme included essential and desirable clinical and management skills along with the support they would need to achieve these skills.
- Records of the education strategy group meeting dated 13 July 2013 showed there was a development plan for the education of nursing staff that was kept under review.

Multidisciplinary working

- There was evidence of multidisciplinary working. This included physiotherapists, dieticians, occupational therapists and pharmacists. When asked what staff were most proud of, they said they were very proud to be part of the multidisciplinary team of the unit.
- Physiotherapists were attached to the unit and worked collaboratively with the nursing and medical staff to ensure patients received the support they required.
- A critical care equipment technician supported staff with the management of equipment.

- There was an effective working relationship with the children's intensive care services at Southampton General Hospital. All children who required airway support were discussed with the clinicians at Southampton General Hospital prior to the decision being made whether to transfer the patient to the specialised children's intensive care unit at Southampton General Hospital or provide short term care and treatment at RHCH. If a child was treated on the critical care unit at RHCH a children's nurse would assist the critical care nursing team in the care and support of the child and their family members.
- A librarian attended the ward round once a week and gathered information about any literature searches required to support staff in provision of care and treatment and their own personal development.
- Follow up of patients once discharged from the unit was not consistent as there was no outreach team. Any follow up on the wards was done by the medical staff on request basis. This meant the unit did not meet the national agreed guidance that "Each hospital should be able to provide a Critical Care Outreach/Rapid Response Team that is available 24/7"
- The unit had an effective working relationship with the organ donation nurse. The organ donation nurse was not employed by the trust, but worked very closely as part of the multidisciplinary team to ensure best possible outcomes with regard to organ donation.

Seven-day services

- The service had consultant intensivist presence on site 24 hours a day, seven days a week. Out of hours the on call intensivist was immediately available for telephone consultation and could access the hospital within 30 minutes. This met the national recommended guidelines.
- A physiotherapy service was available 24 hours a day, with the service being an on call service at night and the weekend. Staff said there was no delay in obtaining physiotherapy support and treatment for patients out of hours and at weekends.
- There were pharmacy and pathology services available seven days a week, with out of hours being an on call service
- Imaging (X-ray) services were available out of hours with a core team of staff on site during day hours and an on call system overnight. However, no interventional radiology was provided on site at the weekend and out of hours. This meant patients had to be transferred to other local acute NHS hospitals if they required interventional radiology out of hours.
- Dietetic services were available during the week. A patient recollected a dietician saw them daily during their stay in ICU.

Access to information

- Patient information and records were held by the patient's bedside so all staff had instant access to patient information.
- All staff had trust email accounts to access updates electronically.
- Communication files were kept for access to information.
- There was a comprehensive store of information folders in that were easily accessible for staff in the unit. This included guidance about specific care topics, including moving and handling, nutrition, self-assessment competencies, safeguarding adults and children, blood gas analysis,
- The paediatric folder contained some guidance that had not been reviewed or updated. The paediatric nutritional guidelines were dated December 2007. There was a Southampton Paediatric Intensive Care Unit (PICU) drug infusion guide dated 2012. The guidelines for children needing endotracheal suctioning were written 24 January 2007 and had a review date of July 2008. However, any paediatric admissions to the unit were discussed with the paediatric intensive care team at Southampton General Hospital who advised and guided on treatment. In the event of the unit treating and caring for a child a children's nurse worked alongside the unit staff to ensure care was provided safety and appropriately.
- Notice boards in staff areas clearly displayed information updates about topics such as pressure ulcer prevention, control of infection practices, the mental capacity act, safeguarding and duty of candour processes.
- Staff meetings were held, during which information was cascaded, records were kept of these meetings.
- The staff rest room displayed information regarding education, clinical governance, equipment, safety and organ donation. The room was used by the full Multidisciplinary team, so all staff had access to this information.

Critical care

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

- Staff we spoke with had an effective understanding of the Mental Capacity Act 2005. There was some uncertainty about how Deprivation Liberty Safeguards impacted on the treatment of patients in the critical care setting. Records from governance meetings evidenced the service was liaising with other critical care services in the local network to share practices in relation to Deprivation of Liberty Safeguards. The records also evidenced they had referred to the Law Society guidelines as to the use of MCA and DOLS in the acute hospital setting.
- Consultants completed a weekly review of all patients in order to make a decision whether patients were being deprived of their liberty and therefore required an application for authorisation to deprive the patient of their liberty. Staff understood this was not a personalised approach to assessing patient, but had implemented this practice whilst seeking further guidance about how deprivation of liberty safeguards impacted on the critical care setting.
- Staff were aware of the need to seek permission where possible from patients prior to providing any care or treatment. We observed informal verbal consent being obtained from conscious patients prior to provision of care.
- Patient records indicated consent was obtained prior to care and treatment being provided. This was confirmed in conversation we had with patients who could speak with us.
- However, we observed one incident where medical and nursing staff delayed challenging a surgical consultant about the manner consent was obtained from the patient for surgery. The consultant surgeon, from previous knowledge of the patient, presumed the patient did not have capacity to make an informed decision about whether to undergo surgery or not. The surgeon failed to follow the statutory principles of the Mental Capacity Act 2005 in that "a person must be assumed to have capacity unless it is established that he lacks capacity." Despite all medical and nursing staff believing the patient did have capacity to give informed consent it was only after the Commission raised this concern that action was taken and informed consent was taken from the patient. All critical care staff we spoke to at the time said they had never known a similar situation occur.

Are critical care services caring?

Outstanding ☆

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

We rated caring as 'outstanding'

Staff demonstrated a clear patient centred a strong ethos and culture when working with patients and their relatives. Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback from patients and their relatives strongly evidenced there was a caring and supportive culture in the critical care unit. Patients describe their amazement about how staff went the extra mile to provide care.

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

Patients and their relatives were active partners in their care. Staff were fully committed to working in partnership with people. For example medical staff worked collaboratively with a patient to find alternative medicines when the patient felt the medicine prescribed was not suiting them.

People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Emotional support was available and provided patients on the unit. Staff involved the patient's family in their care and were trained to deliver bad news and approach relatives regarding organ donation. There was no formal follow up service for patients to discuss their experience in ICU and how it physically and psychologically affected them. However, staff were providing support to patients when they left hospital as they had developed and embedded informal processes.

Critical care

Compassionate care

- We saw compassionate care delivered to all patients on the unit. Staff spoke about the need to always remember when delivering care to a critically ill patient that they were still a person with needs and feelings.
- Patients were highly complimentary about the care and support they received. They were also positive about the staff approach to promoting their dignity. They al told us they were treated with dignity and respect.
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.
- Patients gave us examples of staff going the extra mile in providing care. For example, a patient spoke about their amazement that, when they had little appetite and interest in eating, dietetic staff managed to get them their favourite flavoured soup. The patient told us they believed this was this was "above and beyond the call of duty" of the dietetic staff. A relative spoke about the dignity that was provided to their family member by supporting them to wear their own clothes whilst a patient in the unit.
- Satisfaction surveys were used to seek the views of patients and their relatives about the care and support they received whilst in the critical care setting. The surveys consistently demonstrated a high degree of satisfaction from patients and their relatives. There were also many Thank you cards and compliments from patients and their relatives.

Understanding and involvement of patients and those close to them

- Patients, who we were able to have conversations felt they were well informed and involved in the decision making process regarding their treatment.
- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted over night with any changes in their family member's condition and their wishes regarding this were respected.
- Both patients and their relatives commented that information was discussed in a manner they understood. They said there was always a member of staff available to help them understand the explanations. Relatives said staff explained everything to the patient, even though their understanding might be limited or not known. For example, one patient, who could not remember their first three days in the critical care unit, said that staff had filled in the gaps by explaining what had happened to them in the first three days.
- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce any anxiety. Patients and relatives that we spoke with told us that staff on the unit were very supportive, and explanations about equipment and what was happening helped to reduce their anxiety
- Records of conversations were detailed on patient records. 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.
- Medical staff worked in partnership with patients. For example, one patient gave the example they had felt a certain medicine did not suit them. They discussed this with the medical staff, who took time to discuss alternative medicines the patient could chose to take.

Emotional support

- Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- Breaking bad news was always done with a consultant intensivist, a member of the nursing team and other members of staff as appropriate. This meant there were staff who were known to the relatives available during the breaking of news to provide emotional support.
- For patients whose medical condition meant there was unlikely to be recovery from their illness, their families and/ or representatives were fully involved in decisions to withdraw treatment and commence palliative care. We saw, that when possible, to support families in their grieving process withdrawing treatment or ventilator support was delayed until the patients full family was able to visit and be with the patient during this process.
- Staff said emotional support for patients and their families was available from the trust chaplaincy team who provided support for patients of all faiths and those who did not have a faith.
- Relatives expressed they felt they were getting good support from all staff working in the unit.
- Patients who were able to speak with us expressed their gratitude about the emotional and practical support

staff had provided to their relatives. A patient gave example of support being given to their young child, who was visited them. To cope with the care being given to their parent, staff explained the equipment and treatment in a way the child understood.

- The unit did not offer formal follow-up clinics. This meant there was no formal opportunity for patients once discharged from hospital to be invited to return so their stay and care in ICU could be explained to them to aid them with their emotional recovery. However, there were embedded informal processes to provide support to patients once they had been discharged form hospital. Staff said they always explained to patients and relatives that they could contact the unit at any time to discuss their critical care experience and ask any questions about their care and treatment. If required, appointments were made for the patient to return to the unit to discuss their care and treatment. Some patients who required longer term physiotherapy support after discharge from hospital had appointments from the follow up clinics held at BNHH.
- Staff spoke about how the specialist organ donation nurse provided support and relevant training to equip them with skills to provide emotional and practical support to relatives of patients of differing faiths who were considering organ donation.

Are critical care services responsive?

Good

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

We rated responsive as 'good'

Critical care services were responsive to the individual needs of their patients. The hospital had worked with the clinical commissioning group and currently had a sufficient number of critical care bed.

Staff made reasonable adjustments, such as enabling parents and/or carers to stay and be involved in care for patients with a learning disability. The needs of patients with dementia were considered. Information about caring for people with a learning disability and living with dementia were easily accessible.

The service provided information in the form of leaflets, posters and information on the unit's website, for patients and relatives. However, not all information was accessible for people with visual, reading or dyslexic problems or whose first language was not English. There was 24hour access to interpreting service.

The unit was performing similar as comparable units for out of hour's discharges and delayed discharges.

Follow-up clinics after discharge from hospital are recommended by the National Institute for health and Clinical Excellence (NICE) for patients' on-going treatment and emotional and psychological support. These were not provided as part of the critical care service at RHCH. However, the unit's website had information about what to expect after discharge from hospital and had contact details if patients or their relatives wished to have discussions with the critical care staff.

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

Service planning and delivery to meet the needs of local people

- Following the merger of RHCH and BNHH the critical care management team had worked with the local Clinical Commissioning Groups to ensure there were sufficient numbers of funded critical care beds at RHCH to meet the needs of the local population. The management team spoke about the challenges this process had presented, but now felt there were a sufficient number of beds to meet the local needs.

Meeting people's individual needs

- Information files were easily accessible on the unit to provide support and advice to staff when treating and caring for patients who had a learning disability or were living with dementia. Staff demonstrated in conversations an understanding of adjustments that could be made to support patients with a learning disability or living with dementia. This included enabling family members and/or carers to stay to support the patient during their stay on the unit. Staff knew there were nurse specialists they could contact if they needed advice and support. They said they would find the relevant detail in the information files or on the trust's intranet.

Critical care

- Information about the critical care services was available on the trust website. There was general information that was relevant for both RHCH and BNHH and specific information about the unit at RHCH. There was information about what to expect when visiting a patient on the unit, and what to expect once a patient had been discharged from the unit. This included the impact being critically ill might have including the effect on mood, sleeping and family relationships. However the information on the website was not easily accessible to people who had any difficulties with reading written literature. There was no process to enlarge the writing for people who had visual difficulties. There was no process to change the background colour for people who had dyslexia. There was no process to translate the information. This meant that some people might not be able to fully access the information.
- Information leaflets and posters in the unit were also not accessible in formats other than written English.
- Staff reported there was 24 hour access to translation services.
- We saw that level 1 patients who were waiting for ward beds were encouraged to be as independent as possible, for example being enabled to wash independently and wearing own clothes.
- There was only one visitor's room. We saw the consultant Intensivists' office was used to discuss bad news with relatives, ensuring the conversation was held in privacy

Access and flow

- ICNARC data detailed bed occupancy was similar to that of other comparable critical care units with occupancy in June 2015 being 72%.
- ICNARC data showed discharges occurring out of hours (between 10pm and 7am) were similar to those of similar intensive care units in the country. Data provided by the trust showed that in June 2015 there had been a total of one patient discharge out of the hours, the reason for this was to accommodate a new admission to the unit. Nationally agreed standards for Critical Care detail patients should not be discharged out of hours for safety reasons and because patients perceive it as extremely unpleasant being moved from critical care areas to a general ward outside of normal working hours.
- ICNARC data showed that for discharges with a delay of 4 hours or more between times when the patient was fully ready for discharge and time of discharge the unit performed better than similar units.
- There was no clear data for delayed admissions to the unit. It had been identified from audits that there was an issue with inappropriate referrals to the critical care team, which included referrals being made when not required and referral not been made in a timely manner. Inappropriate referrals were being a monitored and a re-audit was planned to assess whether improvements had been made.
- Cancellation of surgery due to lack of critical care beds was infrequent. Records showed that for June 2015, no surgical procedures were was cancelled.
- Some patients were discharged home directly from the unit. For some patients this was assessed as being the appropriate pathway. This included patients who were admitted for haemofiltration. Processes were in place and followed to ensure patients were discharged home safely with the appropriate support and follow up.

Learning from complaints and concerns

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

Are critical care services well-led?

Good

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

Critical care

Staff were aware of the vision to combine the critical care units from RHCH and BNHH to form one large critical care unit in the proposed Critical Treatment Hospital. However, staff were aware that there was no approved date for the development of this project. Staff were committed to developing a cohesive critical care service across RHCH and BNHH, with the same policies and procedures, training, equipment and staff working across both sites.

Governance processes appropriately managed quality and risks issues, promoted reviews of the service provision and identified areas for improvement.

There was strong leadership of the critical care services and of the critical care unit at RHCH. Within the service there was a culture of support and respect for each other, with staff willing to help the critical care unit at BNHH when they were short staffed.

Innovative ideas and approaches to care were encouraged and supported.

Vision and strategy for this service

- The trust values were displayed throughout the unit and on each computer terminal so staff were fully aware of them. They were: Compassion, caring about our patients and our staff; Accountable and responsible, always improving; Respect for all colleagues, patients and their families; Encouraging and challenging each other to always do our best.
- Staff were aware of the vision to combine the critical care units from RHCH and BNHH to form one large critical care unit in the proposed Critical Treatment Hospital. However, staff were aware that there was no approved date for the development of this project.
- Staff understood and were committed to the immediate strategy to develop cohesive working between the critical care units at both RHCH and BNHH, with both units working to the same policies, guidance and with staff moving between the two units.
- Records from senior staff meetings showed trust values were a constant agenda item and discussions were held about how the unit was working to those values.
- Staff appraisals process included measurements against the trusts values, ensuring they were incorporated into daily working practices.

Governance, risk management and quality measurement

- The senior management team identified the greatest risks for the service were a lack of uniform policies and service operational procedures across both hospitals and a lack of clinical educators for critical care service across both units.
- There were separate risk register for the units. The risk register for RHCH had nine risks identified. The risk covered, for example, pharmacy input to reduce errors, staffing and skill mix, delayed discharges and the need for outreach services. All risks had detail of actions being taken to mitigate those risks. All risks had detail of actions being taken in an appropriate timeframe to mitigate those risks. The risks were reviewed regularly in the clinical governance meetings. We did not, however, identify from the evidence that the higher risks (red risks) were escalated to the trust's risk register to be reviewed by the trust's executive committee.
- Governance meetings were held for critical care services at RHCH and combined senior staff meetings were held for critical care service across both hospitals. Records of these meetings showed that risks to the service, significant events both in critical care and in other areas of the hospital, finances for the trust and critical care services, education, HR issues and clinical effectiveness were considered at these meetings. Updates form actions taken following previous meetings were discussed.
- Monthly dashboards demonstrated quality issues such as prevalence of pressure ulcers, compliance with VTE assessments, delayed and out of hour's discharges and compliance with hand hygiene practices. The dashboards also detailed the four top risks for the service and the mitigating action that was being taken, staff sickness, vacancies and compliance with mandatory training, appraisals as well as progress with the cost improvement programme.
- The unit took part in national surveys to monitor the effectiveness of the service. There was a local audit plan that included small audit projects and larger national and local audit projects.

Leadership of service

- Critical Care Services sat under the surgical division of the trust. One of the consultant Intensivists was the

clinical Director for Anaesthetics and Critical Care and had overall responsibility for the provision of critical care services. There was a medical clinical lead and a clinical service lead at RHCH. All staff spoke highly about the leadership of the unit. They had confidence in the leaders. Staff spoke about the disruption to the service that had occurred after the amalgamation of the two hospitals and how the present leadership team was supporting the service to make improvements and to bring about joined up working of the two units.

- Staff said there was usually a supernumerary coordinator on duty. This made them feel well supported to provide safe and appropriate care for patients.
- Records of senior team meeting dated March 2015 detailed plans for a leadership development programme for Band 6 nurses that would be completed within 6 months of appointment to the unit.

Culture within the service

- There was a culture of recognising achievements and excellence. A WOW award was displayed in the unit which detailed it was presented to "all staff intensive care unit" for work "above and beyond the care". WOW awards are the only UK customer nominated awards for recognising exceptional customer service.
- There was an open and inclusive culture of working. This was demonstrated by the commitment to and pride of working within the multidisciplinary team and by all staff, including student nurses, being invited and encouraged to attend Morbidity and Mortality meetings.
- A member of staff made the comment "they are an awesome team to work with" and commented they had never worked with such a committed and caring team.

Public engagement

- Patient and family feedback was obtained by the use of satisfaction surveys.

Staff engagement

- Information was shared with the team. The staff rest room had large amounts of information ranging from governance, risks, training, trust information and unit social activities.
- Staff meetings and handover periods provided opportunity to engage with staff and ensure information was passed on to staff. Staff confirmed this occurred.

Innovation, improvement and sustainability

- Innovation was encouraged and supported. The unit manager's assistant described how they had been able to develop spread sheets that accurately monitored staff annual leave and mandatory training in a timely way and had introduced an automated text system to alert staff of shifts that needed filling.
- Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff.
- To promote the development of the nursing team the senior nursing team and clinical educator had taken the initiative to develop a critical care career pathway for grades 5, 6 and & 7. This included desirable and essential skills they should be achieving at 0-6 months in post, 6 – 15 months in post and post 15 months in post. The programme included essential and desirable clinical and management skills along with the support they would need to achieve these skills.
- In response to difficulties recruiting middle grade (registrar) doctors the unit had developed a two year course in Advanced Critical Care Practice (ACCP). The planned outcome from this course was that ACCP's would be employed in the unit to fulfil some of the medical tasks and release medical staff to do more complicated work.
- Innovative grab sheets on the unit that detailed required essential equipment needed to care for patients if the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.
- The unit was working to a Cost Improvement Plan to endure sustainability that covered critical care services across both RHCH and BNHH. This incorporated improved income with more accurate coding of patients receiving critical care treatment; procurement of clinical supplies, including streamlining kits across both sites and negotiating better deals with suppliers; cost savings in the use of medicines; and cost savings within staffing and efficient rostering of staff. Effectiveness and progress of the cost improvement was plan was monitored monthly.

Maternity and gynaecology

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

Information about the service

The Royal Hampshire County Hospital is part of the Hampshire Hospitals NHS Foundation Trust. The hospital provides maternity and gynaecological services to the community of Hampshire. Between April 2014 and April 2015 there were 2,708 births at The Royal Hampshire County Hospital.

Obstetrician and midwife led services are based in Florence Portal House. A range of services were provided which included ante-natal, perinatal and postnatal care. There is a Maternity Day Assessment Unit and an Early Pregnancy Assessment unit. Inpatient maternity care is provided on a 11 bed ante-natal ward, the delivery suite contains five labour rooms where care is provided by midwives, obstetricians and anaesthetists. A further two low risk labour rooms are available where midwife-led care is delivered. Two rooms have birthing pools. A further room is used as a bereavement room. Post-natal care for women and babies is provided on a 25 bed post-natal ward.

Inpatient and day surgery gynaecology care is provided on the Anthony Letchworth Ward. There are seven beds allocated for day surgery patients and 13 beds, including three side rooms for inpatients. The operating theatres are situated at the end of the ward; one is for gynaecology patients other for women booked for elective caesarean section. Two emergency theatres are available for maternity emergencies on the labour ward. Gynaecological outpatients' services are also available at this site along with treatment for women who require a termination of pregnancy for fetal abnormality.

During our inspection we spoke with 11 patients, four relatives and 22 members of staff, these included midwives, nurses, housekeeping staff, senior managers and doctors. We observed a shift handover and held focus groups attended by a further four members of midwifery staff. We reviewed seven patients' healthcare records. Before and during and after our inspection we reviewed the trusts performance information.

Maternity and gynaecology

Summary of findings

Maternity and gynaecology services were rated 'good' for providing safe, effective, caring, responsive and well led services.

Nursing and midwifery staff were encouraged to report incidents and robust systems were in place to ensure lessons information and learning was disseminated trust wide.

Midwives followed comprehensive risk assessment processes from the initial booking appointment through to post-natal care. Identified risks were recorded and acted upon across both services.

All areas of the service we visited were visibly clean and systems were in place to ensure nurses, midwives and domestic staff adhered to trust infection control policies and procedures.

The gynaecology ward participated in the NHS Safety Thermometer**.** The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The ward conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. However, information about the audits was not displayed. It is considered to be best practice to display the results of the Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed.

Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance.

Policies and guidelines were developed in line with the Royal college of Obstetricians and Gynaecologists (RCOG), Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust for the maternity service to ensure all services worked to the same guidelines. Staff received further training and support in order for them to develop and maintain their competencies.

The supervisor to midwife ratio was 1:15.

The funded mid-wife to birth ratio was on average 1:30 which met the trust national and local benchmark. However, there were times during April 2014 to April 2015 when the midwife to birth ratio was 1:32-34. The England average was 1:29. Shortfalls in midwifery staff were due to maternity leave and sickness. Midwives had consistently been able to deliver one to one care in labour and there was no evidence to support harm had occurred to women when there had been a shortfall in midwifery staffing levels. The 103 hours dedicated consultant cover exceeded the recommendation of RCOG, Safer Childbirth (2007).

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

The gynaecological service met the referral to treatment time target for women to be treated within of 18 weeks.

Translation services were available, and some midwives had undergone further specialist training to support women with additional needs such as learning disabilities and drug and alcohol addictions.

There was vision and strategy for the service which was focussed around plans for the development of a new hospital. Staff and the members of the community had been consulted about the changes to service provision and had been involved in the architectural design of the new building. Short term strategies had been developed to ensure staff were ready for the move to a new hospital and guidelines were embedded across the sites. However there had not been short and medium term plans for the service development.

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

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

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

We rated safe as 'good'.

Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed.Staff understood their responsibilities to raise concerns and report incidents and near misses.

All clinical areas were appropriately equipped to provide safe care and were visibly clean.

Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities.

Risk assessments were completed at the initial booking and continually evaluated throughout the antenatal, perinatal and postnatal care. These included signs of deteriorating health or medical emergencies.

Consultant presence on the ward exceeded the Royal College of Obstetricians and Gynaecologists good practice guidelines 2010. Consultants conducted ward rounds at weekends and were available on call and overnight to support nursing staff, midwives and junior doctors.

The average midwife to birth ratio was 1:30. There were occasions when this could be higher at times however we saw from performance data that midwives had consistently been able to deliver one to one care for women in labour.

Incidents

- All grades of staff we spoke with were aware of the incident reporting system and system and understood their responsibilities to report incidents, accidents and near misses. They told us senior staff and managers encouraged them to report "anything they were concerned about". Staff told us the system was simple to use, and most of the staff had access to the reporting system. Staff that did not have access to the computer system (for example domestic and housekeeping staff) were clear about their responsibilities to alert the senior member of staff on duty to any areas of concern which may affect the safety of patients. Most staff we spoke with told us they received information via email about the outcome of the incident they had reported.
- Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed. For example, in response to an increase in incident reporting with regards to Obstetric Anal Sphincter injuries (OASI) the trust had implemented further training and guidance which ensured all midwives followed consistent procedures for the prevention of OASI.
- There had not been a never events in the hospital within the last year (May 2014 – April 2015). A never event is a serious, largely preventable patient safety incident which should not occur if the available preventative measures had been implemented). Midwives and nurses told us learning had been shared across the trust wide as a result of a never event which occurred in May 2015 at the Basingstoke and North Hampshire Hospital site.
- We reviewed the records for one patient who had been admitted as an emergency patient prior to our visit. They had previously attended the early pregnancy unit and we read in the notes that the patient had an intra-uterine pregnancy. We noted the patient's notes portrayed a different diagnosis and now required surgery. We could not find any evidence that the missed diagnosis had been reported on an incident form. Nursing staff told us the doctor would have completed an incident form. We were sent the incident reports and noted there was no evidence that an incident form had been completed. We could not be assured that further investigations and learning had taken place to ensure the risk of reoccurrence was minimised.
- Reported incidents and subsequent investigations were presented at regular risk meetings. Midwives and nurses told us this was to ensure learning was shared.
- All reported incidents across the service were discussed at the monthly performance meeting. For example high level risks and patient safety issues such as cardiotocogram (CTG) training. We saw that action plans had been produced to address any areas of concern with timelines for completion.
- Daily trust wide conference calls are held to discuss trust wide concerns. Incident reports for the previous 24 hours were discussed and actions planned for further investigation.

- Hospital trusts have a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm, this is known as Duty of Candour. All grades of staff we spoke with were aware of the principles of Duty of Candour. Staff explained how women were informed about investigations into any incidents which related to the care they had received.
- We were told by senior nurses that there had been no trust wide training, however the incident reporting system contained a section on "openness" to remind staff of their responsibilities.

Safety thermometer

- Anthony Letchworth Ward participated in the NHS Safety Thermometer**.** The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The ward conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. However, information about the audits was not displayed or discussed at team meetings with the exception of infection control audits. It is considered best practice to display the results of the Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed.
- The delivery suite did not participate in the Safety Thermometer audit. They assessed and monitored safety information which was considered to be more appropriate to the service. This information was not displayed in public areas but was accessible to maternity staff via the intranet.
- Patient safety maternity indicators demonstrated that the numbers of major obstetric haemorrhage, admissions to ICU, VTE events, meconium aspiration, neonatal morbidity - readmissions to postnatal ward to were within the local and national benchmark. The number of 3rd and 4th degree tears, VTE assessments, babies admitted to the neonatal unit unexpectedly was above local and national benchmarks (April 2014 – March 2015).

Cleanliness, infection control and hygiene

- All clinical areas were visibly clean and staff were seen cleaning equipment after use.
- On Anthony Letchworth Ward green "I am clean" stickers were displayed on all patient equipment to indicate they had been cleaned and were available to be used.
- We saw staff adhered to the trust's infection control policy. Information was clearly displayed above sinks in all areas to remind staff about correct hand washing procedures. We observed staff were bare below the elbows and were seen washing their hands and using hand gel appropriately.
- Hand hygiene gel was available at the entrances to wards, and departments. Gel was also present at the end of patient's beds and in the delivery and examination rooms.
- Personal protective equipment was available and staff were seen changing gloves and aprons in between patients to prevent the risk of cross infection
- Regular hygiene and infection control audits were performed and learning and actions demonstrated. Monthly infection control audits were conducted across the maternity service. The audits observed a variety of infection control concerns such as hand washing, catheter insertion and commodes. Overall compliance (July 2014 – April 2015) was 100% but there had been three months where the staff in the delivery suite had not been awarded 100% in the monthly infection control audit. Midwives and doctors had been observed performing incorrect hand hygiene practices such as the decontamination of their hands after the removal of gloves. Documentation showed that staff had been spoken with and practices addressed immediately to ensure women were not at risk of the spread of infection.
- Yearly environmental audits were conducted across the service as a whole to ensure the environment was suitable for the delivery of care. We saw areas had been re-audited within the yearly timeframe if it was judged there were areas for improvement.
- On both the Anthony Letchworth ward and in Florence Portal House we saw cleaning check lists displayed outside patient's rooms. The check lists gave information about when the room had last been cleaned and when another clean was due. We saw daily cleaning schedules had been given to domestic and housekeeping staff. The completion of the cleaning tasks had been monitored by both the ward staff and the domestic and housekeeping supervisors to ensure the cleaning had been completed.
- There had not been any reported incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections between March 2014 and March 2015.

Maternity and gynaecology

Environment and equipment

- All of the wards and clinical areas we visited had portable resuscitation trolleys. The trolleys contained medication which was to be used in the event of a cardiac arrest. We saw a daily check sheet which documented all trolleys had been checked to ensure equipment was available and in date.
- Within the delivery suite the baby resuscitaires had lists attached to them to ensure the equipment had been checked on a daily basis. A signature was required to document the checks had been completed. We noted there were gaps in the documentation. Senior midwives told us these gaps in recording had been highlighted to all staff. We observed the completion of equipment checks was discussed at staff handovers throughout the day to ensure all staff were aware that the equipment was safe for use.
- The emergency trolley in the delivery suite contained equipment used in the event of a post-partum haemorrhage. (PPH) is often defined as the loss of more than 500 ml or 1,000 ml of blood within the first 24 hours following childbirth. We noted that although the trolley had been checked the storage of equipment was disorganised. There was the potential that equipment could not be located promptly in the event of a PPH emergency. We also noted the folder used for documentation and guidance during a PPH contained traces of blood. We alerted staff to this to ensure the folder was cleaned.
- The delivery suite environment was organised and equipment was stored appropriately. A range of equipment to aid labour was available. This included two birthing pools, bean bags, baths and birthing balls.
- Equipment in the form of slings was available to evacuate a woman from the birthing pool in the event of a collapse.
- Within Anthony Letchworth ward equipment used to support the delivery of care for example hoists and portable monitoring equipment was stored appropriately. All equipment displayed a sticker which detailed when it had been serviced and tested. We noted that all equipment had been checked within the last 12 months.
- Equipment such as fetal cardiotocograph (CTG) equipment and ultrasound equipment were available in the maternity services. We noted stickers were attached to show the equipment had been serviced and checked within the last year.
- The early pregnancy advice centre was situated at the end of Anthony Letchworth ward, and contained a consulting room and a treatment room. Women who were up to 13 weeks pregnant were able to attend this service. Women over 13 weeks pregnancy attended the Maternity Assessment Unit where further equipment such as cardiotocographs (CTG) was available to support them.
- Security systems were not consistently in place to prevent the unauthorised exit of visitors and babies from the maternity wards. Visitors and staff were required to press a buzzer to enable them to access the maternity areas. However, there was no system in place to monitor people leaving the wards. A button placed on the wall allowed people to leave the wards freely. The system relied on the vigilance of maternity staff to ensure they were aware of who was in the unit. Security concerns were documented on the maternity risk register and we saw a plan was in place to upgrade the security system. Midwives confirmed the security system was to be updated. They told us there had “never been any problems” however parents were reminded to keep their baby with them at all times and notices were displayed to remind visitors not to allow “tailgaters” to enter the unit with them.
- There were two dedicated obstetric theatres. One for elective caesarean sections and the other for unplanned caesarean sections and obstetric emergencies. Both theatres contained sufficient equipment that was checked and regularly maintained to ensure surgical treatment was conducted in a safe timely manner.
- A ‘cell saver’ was available in theatres. This was a medical machine that was able to recover the patient’s own lost blood and re-infuse it into the patient in the event of a major haemorrhage.
- The Butterfly Suite was used for women and families who had experienced a still birth or unexpected death. The room was suitably furnished with soft furnishings and a double bed. There were facilities for refreshments and a shower. This ensured woman were able to stay in the room with their baby if they wished.

Maternity and gynaecology

Medicines

- Medication was stored correctly within locked cupboards and resuscitation trolleys.
- Medication that required storage at low temperatures was kept in dedicated fridges. Fridge temperatures were checked daily to ensure the medication was stored at the correct temperature.
- Although the medication was stored correctly in the fridge within the maternity unit, the medication was not well organised. When we opened the fridge, medicine was at risk of falling out and it was difficult to access medication without removing other medication first. Whilst the medication stored was not for emergency use, there was a risk that medication could not be accessed in a timely manner and medicine may be damaged if it fell from the fridge.

Records

- All the records we reviewed contained relevant risk assessments for example pressure ulcer risk and venous thromboembolism (VTE) assessments.
- A new nursing assessment booklet had been introduced on Anthony Letchworth ward two weeks before our visit. All grades of nursing staff we spoke with told us they had not received sufficient training to enable them to complete the assessment effectively. However, we saw that assessments had been completed and further plans to support any identified risk had been documented.
- Records, were stored securely in lockable trolleys on Anthony Letchworth ward
- Pregnant women carried their own records. These were completed on their initial ante-natal booking and were maintained throughout their pregnancy through to the completion of their care by maternity midwives. The records contained clear plans of care for midwives to follow.
- Each baby was issued with the child health 'red book'. We observed they had been completed by midwives.
- Pre- printed stickers were used to document aspects of the fetal heart trace. New stickers had been developed in response to the concerns over the consistency of interpretation of CTG results.
- When a pregnant woman contacted Labour Line, documentation was completed with regards to the woman's history and current concerns. This information was sent via secure email to the maternity unit if a decision had been made for the woman to attend for further advice. Midwives told us this gave them in-depth information prior to the woman's arrival at the unit and reduced the need for repetitive questions.
- Documentation was completed correctly when a termination of pregnancy had been carried out for fetal abnormality. The HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) had been completed and submitted to the Department of Health as required.

Safeguarding

- All of the patients we spoke with told us they felt "safe". One woman told us "I feel comfortable with them.
- All of the staff we spoke with were clear about their roles and responsibilities and the processes and practices that were in place to keep women safe and safeguarded from abuse.
- We spoke with the senior midwife who had the lead role for safeguarding across the Trust. They described how they worked closely with the lead midwives for substance misuse and mental health to ensure robust protocols were followed if concerns had been raised. Women and babies who were considered at risk were flagged on the computer system and pathways were in place to enable all midwives to care for them appropriately. Joint working had been established with external agencies and monthly meetings were held to discuss any areas of concern. Information was disseminated to community midwives and health visitors to enable them to support women and babies in the community.
- All of the midwives we spoke with described the safeguarding lead as approachable and felt they could contact them at any time for help and advice if required.
- An audit had been conducted in November 2014 to assess compliance in the completion of the management plan used for safeguarding children and maternity cases. The audit was conducted to assess if compliance met with the guidance produced by the trust (maternity safeguarding children guidelines 2014) and the local safeguarding children board (4LSCB Maternity and Children's Services Department unborn babies protocol 2011 (revised 2013)). The audit found

areas of good practice and areas for further improvement. An action plan and further recommendations were developed with deadlines for completion.

- Maternity and gynaecology staff had attended mandatory safeguarding training updates to ensure their knowledge was up to date. The trust target for attendance was 80%, we saw that 92% of nursing and midwifery staff had attended safeguarding adult's updates and 92% had attended safeguarding children updates.
- The attendance of doctors at safeguarding update training was 75% which was slightly below the trust target of 80%.

Mandatory training

- The majority of staff attended mandatory training to ensure they had suitable training to care for women safely. Staff attendance at training for health and safety, information governance and manual handling was close to or exceeded the trust target of 80%. However, the compliance of staff attendance at infection control training did not meet the trust target. We noted that 50% of medical staff and 60% of nursing and midwifery staff had attended the training updates. There was a risk that not enough staff had attended updates to ensure appropriate infection prevention and control.
- Midwives and obstetricians undertook further role specific skills and drills prompt training practical emergency obstetric training (PROMPT**)** neonatal life support and fetal monitoring.

Assessing and responding to patient risk

- Risk assessments were completed on the initial maternity booking and continually evaluated throughout the woman's pregnancy. However, the service did not meet the trust target of 95% for women assessed for the risk of venous thromboembolism (VTE) across both services. The assessment of VTE was monitored on the Maternity Dashboard to ensure compliance with assessments. The target for assessments was 95% and we saw between April 2014 and April 2015 the hospital achieved 91% compliance against this target. During the twelve month time frame there had been no occurrence of a VTE in any patients.
- Midwifery staff completed the modified early obstetric warning score (MEOWS) to assess women's observations. This was a system that enabled midwives to record observations and gave protocols for staff to follow if the observations deviated from the woman's norm.
- Midwives working in the delivery unit used the 'fresh eyes' approach for fetal monitoring. Different Midwives regularly checked recordings from the CTG machine to ensure any anomalies in the fetal heart trace had not been missed by the midwife responsible for the woman's care. The incorrect interpretation of the CTG recordings was documented on the maternity risk register and systems were in place to mitigate the potential risk to women and the safe delivery of their baby. Monthly audits were conducted and recorded on the Maternity Dashboard. The trust target was 100% for completion of 'fresh eyes'. For the period April 2014 to March 2015 the unit reported six months where they achieved the 100% target. Further training and awareness sessions had been organised to ensure the unit achieved the 100% target consistently.
- Nursing staff completed the early warning scoring system (EWS) on Anthony Letchworth ward. The scoring system enabled nurses to assess patient's observations and provided protocols to follow if the observations varied from the patient's norm.
- Senior nurses completed monthly audits to assess risks to patient care had been identified, this was known as 'Audit R'. 10 patient's notes per month were audited to ensure they had been accurately completed and risks had been identified and plans developed to minimise the risk. These results were displayed on boards in the ward and covered areas such as food and nutrition, pain, infection control and mental health needs. The results of 'Audit R' were discussed at monthly team meetings and we saw from the minutes of the meetings that discussions had taken place to ensure staff were aware of areas for improvement.

Midwifery staffing

- We spoke with six patients on Anthony Letchworth ward. All the patients told us staff answered their call bells very quickly and there always seemed to be sufficient staff working on the ward.
- All grades of nursing staff on Anthony Letchworth ward felt there were enough staff to care for women safely. They had one vacancy for a part time trained nurse which they hoped to fill in the near future.

- Midwives of all grades told us there were times when they were very busy and felt as if they did not have enough staff. One senior midwife told us there are definitely times when there are not enough midwives to look after women and staff were working longer hours.
- The funded mid-wife to birth ratio was on average 1:30 which met the trust national and local benchmark. During April 2014 –April 2015, the average midwife to birth ratio was 1:30, however there had been five occasions when the ratio had been higher at 1:31-34 due to sickness and maternity leave. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states there should on average be a midwife to birth ratio of 1:28. The England average was 1:29. We saw from performance data that midwives had consistently been able to deliver one to one care for women in labour.
- The deputy manager for women's health told us they were due to commence a trust wide service review in September. In preparation for this they were currently performing an overall assessment of the service provision using the 'Birthrate Plus' acuity tool ('Birthrate Plus' is an assessment tool that provides a comprehensive assessment of the staffing needed to provide the care required by a woman in the maternity services).
- The midwives we spoke with told us about a recent meeting which was held to discuss staffing levels. We reviewed the minutes and saw that action plans had been devised to address the current shortfall in midwives due to annual leave, sickness and maternity leave. These plans included a review to the current shift patterns to enable midwives to work more flexibly, the use of specialist non-clinical midwives in clinical areas and the on-going recruitment of further staff. Midwives told us that although they felt at times under pressure and were unable to take breaks, they did not feel that the service was unsafe and they were able to one to one care when a woman was in labour.
- We reviewed the safer staffing report for June 2015 and saw the midwives had consistently achieved 100% one to one care for women in labour, throughout the month. The safer staffing report also documented occasions when midwives had completed incident forms to highlight shortfalls in staffing numbers. We reviewed this information and saw that there were occasions when there was a delay to the delivery of care over fours, for example, for induction of labour. However patient safety was maintained during these periods. Midwives told us they were able to access further support from other maternity services within the trust if they required. For example the community midwives or midwives who were based at Andover Memorial Hospital.
- The current nurse and midwife sickness rate was 3.7% trust wide which was above the trust target of 2.6%. Senior managers told us they were investigating new ways to monitor and respond to sickness levels within the service.
- We observed the morning handover in the maternity services. The handover was well attended, by midwives, specialist doctors, two consultants, consultant anaesthetist, trainee anaesthetist, and a risk midwife. The staff reported on expected births and on-going home births. Ante natal patients and staffing levels and discharges were also discussed. All the cases discussed were listed and kept as a record of the handover.

Medical staffing

- The trust had devised a system to ensure sufficient senior doctors were consistently available. Some Doctors were similar in position to that of a junior consultant and were fully trained and were called locum consultants. The Royal College of Obstetricians and Gynaecologists good practice guidelines 2010 state the recommended consultant cover for a maternity unit which delivers between 2500 and 4000 births a year should be 60 hours a week. The maternity unit exceeded this by consistently providing 82 hours a week of consultant cover**.** Six consultants worked on the non-resident rota and supported middle grade doctors. A further two consultants were on the resident on call rota and were first on call with junior doctors. There were also five registrars and one speciality doctor.
- There were dedicated consultants during the day who only covered the labour ward. This was to ensure consultants were available at all times.
- Elective caesarean sections were done daily. There was a separate theatre team for obstetric emergencies theatre who were available all day**.**
- There was anaesthetic cover available throughout the day and night. Trainees and middle grade doctors had undertaken further training in obstetric anaesthesia which ensured they were competent to care for women in labour. There was consultant obstetric anaesthetic

cover for 14 hours per week which met the Association of anaesthetists Great Britain and Ireland (AAAGBI) guidelines. Consultant anaesthetists were available on call for further support if required.

Major incident awareness and training

- Staff were aware of their roles and responsibilities in the event of a major incident. Staff told us they had received training and we saw the plan was readily available on the trust wide intranet. Business continuity plans were available for staff to follow to ensure routine care was delivered in the event of a major incident.

Are maternity and gynaecology services effective?

Good

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

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

We rated effective as 'good'.

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

guidance. They were monitored and audited to ensure consistency of practice.

A range of equipment and medicines were available to provide pain relief in labour and for patients on the gynaecological ward. Women were able to self-administer pain relief if required.

Women had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.

Breast feeding was encouraged and the midwifery services had achieved accreditation with UNICEF UK breast feeding standards.

Staff had access to training to develop and maintain their competencies. The supervisor to midwife ratio was in line with national guidance of 1:15.

When people received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services worked together and assessed, planned and delivered peoples care and treatment collaboratively.

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

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence based guidance. For example the trust had recently developed comprehensive guidelines in response to the Human Tissue Authority (HTA) guidelines for matters relating to fetal loss and termination of pregnancy for fetal abnormality.
- Policies and guidelines were developed in line with the Royal College of Obstetricians and Gynaecologists (RCOG), Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been reviewed and unified across the trust for the maternity service to ensure all services worked to the same guidelines.
- Gynaecology cancer services were delivered in line with the central and south west agreed guidelines for care.
- The hospital promoted natural birth and the hospital figures for April 2014 to March 2015 showed that 56% of women had normal deliveries which was slightly lower than the England average of 60%
- The hospital elective caesarean rate for April 2014 to March 2015 was 14% which was above the 10% local and national benchmark. All grades of midwives told us they actively promoted the benefits of natural childbirth. They encouraged women to attend active birth classes and discussed options with women in line with NICE quality standard 22.
- There was an on-going audit programme to evaluate care and change practice if required. For example a retrospective audit suggested the use of customised growth charts would detect small for dates babies (unborn babies whose size was not commensurate with their due date). The unit was using the new charts and there was an on-going audit to check whether the charts were effective. The audit programme was a joint programme with Basingstoke and North Hampshire Hospital.

- Rolling audits were performed to continually assess the delivery of care these included post-partum haemorrhage and babies born before arrival at a maternity centre.

Pain relief

- Patients on Anthony Letchworth ward reported that they received pain relief in a timely manner. One patient told us "They ask me regularly if I would like any pain killers". Patients on Anthony Letchworth ward had pre-operative and on-going assessments for pain during their stay.
- Women were able to have epidural analgesia on the delivery suite. Women were able to manage their epidural pain relief. Patient controlled epidural anaesthesia equipment was available to enable women to control the amount of pain relief they required. If women requested to have an epidural the aim was to ensure she received it within one hour. If this request was not met within the hour an incident form was completed and reasons for the delay investigated. The hospital episode statistics (HES) maternity statistics for 2013/2014 showed the England average for women receiving an epidural as 16.4%. Data from the trust for June to November 2014 showed that 31.15 % of women received an epidural.
- Midwives assessed women's pain regularly and there was guidance to follow for the administration of analgesia.
- Women in labour had access to a variety of equipment to aid pain relief such as birthing balls, bean bags and two birthing pools.

Nutrition and hydration

- There were protected meal times on Anthony Letchworth ward to ensure patients were not disturbed whilst they ate their food. All of the patients on the ward told us the food was good. One person told us "there is plenty of choice". Another patient told us "the food is really rather good". Patients on the ward had their nutritional status assessed using the Malnutrition Universal Screening Tool (MUST). Referrals were made to the dieticians if a patient required further support with their nutrition.
- The trust had recently received accreditation with the UNICEF Baby Friendly initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed by UNICEF.
- The trust target for breastfeeding initiation was 80%. Between March 2014 and March 2015 the hospital had met or exceeded this target 11 times

Patient outcomes

- The maternity services provided effective care, treatment and support to pregnant women living in the locality, before, during and after birth. Information relating to the measurement of outcomes was monitored by the use of performance dashboards within both the maternity and gynaecology services.
- The maternity performance dashboard displayed monthly outcomes and local and national targets. We received the dashboard for March 2014 –March 2015. A wide range of outcomes and targets were measured including numbers and types of births, delivery methods, referrals and caesarean section rates. The dashboards were reviewed at regular departmental meetings to identify any areas for improvement.
- The hospital promoted natural birth and the hospital figures (April 2014 to March 2015) showed that 56% of women had normal deliveries which was slightly lower than the England average of 60%
- The hospital elective caesarean rate (April 2014 to March 2015) was 14% which was above the 10% local and national benchmark. Ventouse delivery was 7% which was the same as the benchmark; forceps delivery was 7% below the benchmark of 8%. All grades of midwives told us they actively promoted the benefits of natural childbirth. They encouraged women to attend active birth classes and discussed options with women in line with NICE quality standard 22
- The gynaecology performance dashboard showed performance outcomes however there was no comparison with local and national targets, with the exception of the referral to treatment time of 18 weeks for patients requiring surgery.
- Patients on Anthony Letchworth had access to enhanced recovery protocols to facilitate a shortened length of stay on the ward.
- Outcomes of care delivery were audited on a regular basis. For example there was an on-going audit conducted by the ante natal clinic lead in response to the increasing incidence of gestational diabetes. Results of the audit would be used to confirm criteria required for use of the glucose tolerance test for women who had been shown to have glucose in their urine.

- The hospital had recently participated in the multi-centre national antiepileptic drug management in pregnancy (EMPiRE) study. They had completed their submissions and were awaiting publication of the results.
- In response to a rise in unnecessary referrals for a consultant appointment, midwives audited the reasons for referral and subsequently adjusted the booking and referral form to include more specific reasons for referral. As a result referral rates had declined which resulted in a reduction in unnecessary referrals and visits to hospital.

Competent staff

- Staff across both services had the necessary skills and experience to provide effective care and treatment.
- Staff on Anthony Letchworth ward told us they had access to further training to ensure they were competent to care for the patients on their ward.
- Some nurses and midwives had undergone further training to enable them to use sonography (ultrasound) to facilitate prompt investigation for fetal growth and movement. Some maternity support workers had undertaken further training in venepuncture.
- Some midwives had undertaken further training and development to support their role. For example midwives had received training to be able to conduct the NHS New-born and Physical Examination Programme. These checks were completed to detect and promptly treat a number of congenital medical conditions.
- Midwives and obstetricians took part in annual skills and drill training for obstetric emergencies such as post-partum haemorrhage and shoulder dystocia.
- Appraisal rates were recorded jointly across the maternity and gynaecology service. We saw from records that staff were not consistently supported to have an appraisal. The trust target was 70%. We saw for the year April 2014 to April 2015 60% of Consultants (or equivalent grade), 50% of non-clinical band 7-9 nurses and 62% of nursing and midwifery staff band 7 and below had received appraisals. 55% of healthcare and maternity care assistants had also received appraisals. This meant that some staff had not been given an opportunity to discuss areas for improvement or further development in their role.
- The colposcopists received accreditation 3 yearly with the British Society for Colposcopy and Cervical Pathology (BSCCP).
- All midwives were assigned a supervisor of midwives. The regulation of midwives includes an additional layer of supervisory responsibilities provided by a supervisor of midwives (SoM).The supervisor of midwives is someone who has been qualified for at least three years and has undergone further training to enable them to fulfil the role. (rule 8, Nursing and Midwifery Council (NMC) 2012) .The supervisor of midwives provides advice and support, audits midwives record keeping and investigates any areas of concern relating to practice. The supervisor to midwife ratio was 1:15 which equalled the recommended ratio of supervisors to midwives
- The local supervising authority midwifery officer (LSAMO) had recently conducted an audit of the supervision of midwives across the trust. The role of the LSAMO is to ensure that the requirements of the nursing and Midwifery Council are met. The audit for 2014/2015 showed that the supervisors of midwives across the trust were achieving the standards for the statutory supervision of midwives as set out by the Nursing and midwifery council and cited in The Midwives Rules and Regulations (NMC,2012)
- The Health Education Wessex dean's report, published on the General Medical Council (GMC) website, documented good practice in training for specialist trainee second year (ST2) and higher level doctors.

Multidisciplinary working

- Staff consistently told us they worked well as a team.
- Specialist senior non –clinical midwives told us they helped out across the unit when required. This was confirmed by the midwives we spoke with.
- Our observation of practice, review of records and discussion with staff confirmed there were effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of people's needs. For example the handover and ward rounds on the maternity unit were well attended by the multidisciplinary team such as, doctors, midwives, anaesthetists and theatre staff. This promoted effective communication and gave the opportunity for shared decision making.
- Midwives reported good support from the staff who worked in the neonatal unit.

- Midwives in the hospital worked closely with the community midwives to ensure the effective exchange of information.
- The Labour Line midwife was based in the ambulance call centre. This meant the midwife was able to liaise closely with ambulance staff and prioritise ambulances if required.
- The safeguarding lead nurse worked closely with external agencies such as social services to ensure women and babies were safeguarded.

Seven-day services

- Consultants were present during weekends on the maternity unit. They were available for advice and support by telephone during the night.
- If an anaesthetist was required out of hours they were contacted via the bleep system. Out of hours cover was provided by a competent anaesthetist who was usually a consultant during the day (at weekends) and a middle grade or registrar anaesthetist at night. We were told there is also an on call consultant anaesthetist who is available for guidance and support out of hours.
- The maternity assessment unit was open on Saturday and Sunday from 10am to 4.30pm.
- A Midwife sonographer was available at weekends to cover the whole trust for community patients. This meant a woman may be asked to travel to another hospital in the trust if they required a scan at the weekend.
- The early pregnancy advice unit was not open at weekends. If women required advice over the weekend they attended the emergency department and could then be sent to Florence Portal house if further investigations were required Radiology and MRI were available at weekends.
- A pharmacy cupboard was available for 'common' medication if required for example antibiotics. There was an on-call pharmacist for other medication if required.
- Haematology services were available out of hours for urgent blood tests and any gynaecological or maternity emergency.

Access to information

- Pregnant women carried their own records. These were used by all clinicians involved with the woman's care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used during their post-natal care.
- We saw in women's notes the SBAR (situation, background, assessment and recommendation) communication tool. The tool was used to ensure all relevant concerns and history about a women's medical condition had been communicated effectively.
- Medical records were created in the form of the 'red book' for each baby.
- Ward staff on Anthony Letchworth ward told us they had access to the relevant records for patients in their care.
- Records of information given and received via Labour line were sent to the maternity unit via secure email if women were requested to attend for further investigation

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients on Anthony Letchworth ward told us they were asked for their consent prior to any medical intervention. One woman told us "they tell me everything" and another patient told us "they explain everything, then ask me if I am happy to carry on". Women in Florence Portal house told us they had sufficient information to enable them give informed consent.
- Nursing assessment documentation on Anthony Letchworth Ward contained procedures to follow if a patient required a Deprivation of Liberty Safeguard (DoLS). During our visit there were no patients subject to Deprivation of Liberty Safeguards.
- Throughout our visit staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

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

We rated caring as 'good'.

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

Women told us they felt involved with their care, had their wishes respected and understood.

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

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

Midwives were trained to provide emotional support, for example, for women who may have bereavement. There were also specialist support and counselling services available.

Compassionate care

- Patients on Anthony Letchworth ward told us staff were kind. One patient told us "I have never known kindness like this, they are marvellous". One patient told us "the bed is very comfortable and the pillows-I have enjoyed my holiday!"
- We observed throughout our visit that women were treated with respect and dignity. Curtains were drawn around patients on Anthony Letchworth ward when personal care was delivered. On the delivery suite we observed midwives knocked on doors and waited to be allowed to enter.
- Visiting times were waived for partners of women who were in labour. Midwives were surveying staff and patients to assess whether they would be comfortable to allow partners to stay continuously on the post-natal ward after the babies had been born.
- The trust participated in the Friends and Family test. The response to the Friends and Family test had grown from June 2014. In February 2015 49% of women had completed the test to give feedback about the service compared with the England average of 24%. On the whole the percentage of women recommending the service was higher or in line with the England average, with the exception of the post-natal community provision where the results varied significantly throughout the recording year of March 2014 to February 2015.
- The CQC Survey of Women's Experiences of Maternity Services 2013 showed the trust wide service was performing the same as other trusts for all of the questions and better than other trusts for the question' "if your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?'
- On Anthony Letchworth ward a patient had been identified as being in the last days of life. The patient's relative was also an in-patient at this hospital. Nursing staff told us the couple had been together for 80 years and staff felt it was appropriate to provide care to both patients in the same side room. Staff spoke passionately about being able to provide care to both patients to enable them to spend as much time together as possible.

Understanding and involvement of patients and those close to them

- Women across both services told us they were given sufficient time to ask questions and had enough information about their care.
- We observed nurses explaining care and involving patients in plans for discharge during our visit.
- We saw from women's records that discussions had taken place with regards to choices in pregnancy care and information was given to enable women to make informed decisions about where they would like to deliver their baby. The women we spoke with told us they had the opportunity to visit the unit prior to the delivery of their baby to ensure they felt comfortable in the environment.
- All women had a named midwife and this was documented, along with the midwives contact details, in the front of their hand held notes. This was to ensure women were able to contact their midwife if they required further information or advice.

Emotional support

- Women had access to specialist perinatal midwives to enable them to discuss any anxieties about giving birth.
- Assessments were undertaken to detect if women required further support for mental health needs.
- Women were able to access further support and counselling if they had undergone a termination of pregnancy for fetal abnormality.
- All of the midwives had attended mandatory bereavement training. The service also employed specialist bereavement midwives and had close links with the Stillbirth and Neonatal Death charity (SANDS). In the event of a stillbirth or unexpected death, women and their families were cared for sensitively away from areas where women had delivered their babies

Are maternity and gynaecology services responsive?

Good

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

We rated responsive as 'good'.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.

Women were able to choose the most appropriate place to receive their ante-natal care. This included their homes, GP practice or the Maternity Centre at Andover War Memorial Hospital.

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

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

Women had access to gynaecological services within the set target time. The referral to treatment target (RTT) set by the Department of Health of 18 weeks was met.

The needs of different people were taken into account when planning and delivering services. For example women had access to specialist services for complex pregnancy and mental health needs.

Complaints and concerns were taken seriously, and listened to. Improvements are made to the quality of care as a result of complaints and concerns

Service planning and delivery to meet the needs of local people

- Most routine ante natal and post-natal care was carried out by community midwives. The community midwives (employed by the trust) provided care in community venues to suit individual women. Women told us they were able to choose where they would like to have their ante-natal care. If women had more complex health needs they attended multi-disciplinary clinics held at the hospital.
- The consultant anaesthetist ran twice monthly anaesthetic clinic to assess women prior to labour. The consultant saw women who had chosen to have a caesarean section to assess if women had any underlying conditions that may create a risk. For example women with long term back conditions, medical problems or women that had a body mass index (BMI) greater than 40. The clinic was held to facilitate the discussion of plans prior to their chosen delivery date.
- The senior staff on Anthony Letchworth ward told us there were times when they had surgical outliers, however this did not impact on their ability to carry out their booked gynaecology operations. During our visit there were three surgical outliers. Ward staff told us they were regularly visited and reviewed by their appropriate surgical teams. We witnessed the surgical team reviewing patients on the ward.
- Pregnant women were able to call the labour line midwives based at the local ambulance control centre for further advice. The midwife discussed their birth plan and made arrangements for their birth and on-going care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners if their chosen location for birth was stretched to capacity.

Midwives told us that it was unusual for a woman not to be able to give birth in her chosen place. Labour line midwives were able to prioritise ambulances to women in labour if they were considered an emergency.

- Systems were in place to review service plans to meet the needs of local people. The Maternity Services Liaison Committee (MSLC) was attended by members of the public and local maternity commissioners. The chair of the MSLC told us they had been asked for their views and feedback with regards to future plans for the service and had used social media to gain feedback form women about the current services on offer.

Access and flow

- The maternity assessment unit (MAU) was open Monday to Friday 8am to 8.30pm. The unit was staffed by midwives who managed most of the care and decided if any follow up treatment was required. Women were able to make appointments to attend the unit or were referred by their GP, midwife, or labour line. 18 pathways were displayed on the wall by the nurses' desk. The information displayed comprehensively covered most of the conditions that women may present at the MAU with. The pathways gave midwives guidance and treatment plans that facilitated timely diagnosis and treatment. Doctors who worked on the labour ward were contacted for further advice and support if required. The unit had one midwife sonographer each day that had undergone further training which enabled them to use ultrasound machines and interpret their results. Approximately 20-30 women attended daily for further tests or examination, and community midwives were able to refer women to the unit to confirm the presentation of their baby. Midwives told us this saved time for women and reduced unnecessary appointments
- The early pregnancy advice unit (EPAU) was open from 8.30am to 8.30pm Monday to Friday**.** Women were referred to the EPAU via their GP, practice nurse or midwife. The nurse led clinic enabled women to have prompt access to early pregnancy related problems, ultrasound scans and blood hormone tests (HCG and progesterone).Women diagnosed with a miscarriage or ectopic pregnancy were offered a choice of conservative (natural), medical or surgical treatment options.
- Women had access to gynaecological services within the set target time. The referral to treatment target (RTT) set by the Department of Health was being met and over 92% of patients to on a waiting list for treatment for less than 8 weeks. This was based on figures between December 2014 and May 2015.
- The maternity unit had never closed during the period of November 2013 and April 2015 which ensured women in the locality had consistent access to maternity services.
- The trust wide bed occupancy rates for maternity and gynaecology were lower than the England average. For example for quarter two 2014/2015 the trust reported a bed occupancy rate of 37.4% compared with the England average of just under 60%.
- Pregnant women had prompt access to maternity services. The national and trust target for booking women for ante natal care by 12 weeks and 6 days gestation was 90%. The hospital consistently exceeded the trust and national targets for the year April 2014 to March 2015 with an average of 98.6% of women booked within the timeframe.
- Women had streamlined access to ante-natal services. Once a booking form had been received at the maternity unit an automatic scan and blood appointment was sent to the women's preferred ante natal clinic. Daily blood test results were sent to the maternity service and high risk results reviewed by a screening midwife. Women with high risk test results were offered face to face appointments for further tests if required.
- Discharge information was sent to community midwives and GPs when women were discharged from the services. This was to ensure they were aware of the treatment women had received during their admission to hospital.

Meeting people's individual needs

- Women and families who had experienced a still birth or unexpected death had access to a dedicated area called the Butterfly Suite. This area was away from the main body of the ward and contained a bed, chairs, and hot drink making facilities to ensure people were as comfortable as possible.
- There were specialist midwives trained to meet a variety of complex needs. For example drug and alcohol dependency, learning disabilities and teenage pregnancy. These midwives were assigned women to support throughout the duration of their pregnancy to provide consistency of care.

- Women had access to perinatal mental health services. Women were usually identified on booking, and a referral made to the perinatal mental health team who planned care and supported the woman throughout her pregnancy.
- Weekly consultant led diabetic clinics were held. Women had access to support from dieticians and midwives to ensure they were confident in the management of their diabetes during pregnancy.
- A specialist midwife held weekly epilepsy clinics. The midwife was able to prescribe medication and worked closely with a neurology consultant to ensure pregnant women had appropriate access to specialist care if needed.
- Women told us staff provided personalised care and treatment. We saw birth plans that had been discussed with women and women told us they had been given sufficient information to allow them to make choices about their delivery.
- Booklets were provided for women by the trust in line with NICE guidelines. The booklets contained information about the three care settings that were available Basingstoke and North Hampshire Hospital, The Royal County Hospital in Winchester and the midwife led Maternity Centre at Andover War Memorial hospital.
- Information that covered a wide variety of maternity and gynaecological concerns was displayed throughout the areas we visited. Staff told us that they were able to access printed information in other languages if required. The senior nurse on the gynaecology unit told us there was access to translation facilities via a telephone service if required.

Learning from complaints and concerns

- Complaints were monitored on the maternity and gynaecology dashboards. The maternity dashboard displayed information from April 2014 to March 2015. We saw the service had received 20 complaints during that time frame. The gynaecology dashboard showed that between June 2014 and June 2015 the service had received 17 complaints.
- The gynaecology ward displayed "You said; we did" boards. The aim of this board was to display any complaints or concerns that had been raised by patients and relatives and to show what learning and change of practice had occurred in response to the complaints. We noted that the comments and complaints were the same on both sites we visited and did not reflect any particular information pertinent to individual wards.
- Information was displayed in patient's areas to inform them about how to make a complaint.
- Senior managers told us in a response to recent concerns raised by pregnant women they were about to conduct a pilot study at BNHH to allow partners to stay with women consistently after they had delivered their babies.
- Senior staff told us the development of labour line had been in response to concerns raised by women. Pregnant women had experienced difficulty in contacting midwives when they were in the early stages of labour. Labour line was developed to ensure women always had a single point of contact and midwives had received extra training to ensure they were competent to provide telephone advice.

Are maternity and gynaecology services well-led?

Good

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

We rated well led as "good."

There was a clear statement of values driven by quality and safety. There was strategy and vision for the service which was focussed on plans to develop a new hospital. Staff and the members of the community had been consulted about the changes to service provision and had been involved in the architectural design of the new building. Short term strategies had been developed to ensure staff were ready for the move to a new hospital and guidelines were embedded across the sites. However there had not been short and medium term plans for the service development.

There were comprehensive risk, quality and governance structures and systems were in place to share information and learning. Staff across the service described an open

culture and felt well supported by their managers. Staff continually told us they felt "proud" to work for the trust and that their successes had been acknowledged and praised by the trust board.

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

Vision and strategy for this service

- All staff we spoke with were aware of the trust wide values and were able to describe them to us. These were designed to form the acronym CARE and were compassion, accountability, respect and encouraging.
- The trust had produced a clinical strategy for maternity and women's health. The strategy detailed plans for the future development of the service within the proposed new critical treatment hospital. The new treatment hospital was to be built on a new site between the two main hospitals in the trust. The vision was to create midwifery led care at Basingstoke and North Hampshire hospital and the Royal County Hospital. A further midwifery led unit alongside obstetrician led care was proposed for the new site. In addition the new critical treatment centre would have facilities for gynaecological care. Gynaecology services would remain at the two existing sites.
- All of the staff in the maternity services were aware of the vision for the service. Senior midwives told us they had been consulted about the design features and all staff were excited about the potential of the new unit. One consultant told us they aimed to provide 24 hour resident consultant presence in the new unit.
- All other staff we spoke with were aware of the plans for the new hospital and had been involved in plans for their service.
- Senior managers for the service told us that their short term strategy was to ensure all staff were ready for the new hospital and to ensure all guidelines were harmonised within the trust. The service did not have a clinical strategy to address short and medium priorities for the service.

Governance, risk management and quality measurement

- The maternity and gynaecological service had a clear governance structure. Within the maternity service the labour ward held monthly forums to discuss areas of concern or practice. Further service wide meetings were held which oversaw quality, audit, risk activity and performance. For example monthly performance reports were linked to service dashboards and reports were reviewed in monthly business unit meetings, which were discussed at board level.
- Specialist risk midwives were employed to assess risks to care delivery. Maternity risks were discussed at the monthly risk management forum attended by a variety of staff including consultants, midwives, anaesthetists and students. The forum consisted of case presentation and discussion to facilitate learning from incidents, risks and complaints.
- Senior managers demonstrated an understanding of current service risks. There was a dedicated risk register for the maternity service. The highest risk was the correct interpretation of CTG traces. Other risks included the availability of a second theatre team, midwifery staffing, and damaged sinks in the labour ward. There was a dedicated risk manager for the service who worked across all sites in the trust. The risk manager demonstrated an awareness of the risks and there were mitigating actions and subsequent action plans to reduce further risks. The risks were reviewed regularly in the clinical governance meetings. We saw from minutes of meetings that all risks and incidents were presented at risk meetings and learning was shared across the trust. We did not, however, identify from the evidence that the higher risks (red risks) were escalated to the trust's risk register to be reviewed by the trust's executive committee.
- Quality control systems were in place to ensure screening images were of good quality. A senior sonographer regularly audited images to ensure the images were of sufficient quality.

Leadership of service

- All staff spoke positively about the board members and in particular the chief executive for the trust. They told us they were visible and approachable.
- All staff we spoke with were positive about their relationships with senior and immediate managers.
- The senior nurse for gynaecology was described as visible and approachable, one member of staff told us "she has worked her way from the bottom to the top; she knows what it's like".

- Midwives described their senior manager as “absolutely amazing, a positive influence and very visible”.
- Senior managers spoke passionately about the staff. They told us they were “very proud” of their teams and demonstrated they had a clear understanding of the concerns midwives and nurses had on a day to day basis. For example they understood concerns regarding staffing levels within the maternity service. They had held meetings across the trust to talk to staff about their concerns and plans for further recruitment. We saw from minutes of the meetings that staff had been able to discuss areas of concern and action plans had been produced to address these.

Culture within the service

- All staff told us they felt confident their concerns would be listened to and honesty and openness was encouraged.
- Senior staff worked closely with colleagues across all of the trust sites to ensure information was shared. Staff reported that probably more needed cross site working was needed between services across RHCH and BNHH.
- During our visit we observed staff interactions with each other and managers. We saw that staff treated each other with respect and they were able to speak freely with managers. Interprofessional relationships between doctors and midwives were described as good.
- Success was celebrated within the trust. The staff on Anthony Letchworth had won a Director of Nursing award. Senior staff had used the money awarded towards a team building day and a champagne lunch to “thank the staff for all their hard work”.
- Midwives and midwifery managers were extremely proud of the success of their service. The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they had also been awarded second place in the Midwifery Service of the Year Award.

Public and staff engagement

- The Maternity Service Liaison Committee (MSLC) represented women who had used the maternity service. They met 10 times a year. The chair of the committee told us they were involved in the work as to whether partners could stay over. Social media was used to gather feedback from women and surveys were conducted to ensure the views of women who used the service were taken into account.
- The Chief Executive for the trust encouraged direct feedback about care received in all areas of the trust. The trust internet page contained a link where patients and relatives were able to contact the chief executive directly.

Innovation, improvement and sustainability

- The development of labour line in partnership with South Central Ambulance Service NHS foundation Trust was the first of type in the country. There were plans to develop the service further to provide cross county work. Senior managers told us other Trusts were considering developing this service and they would provide support and guidance if required.
- Plans for sustainability and improvement of the service were directly aligned to the proposed new hospital. Workforce plans had been developed and on-going work was being undertaken to ensure staff were ready for the proposed moved.

Services for children and young people

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

Information about the service

Services for children and young people at the Royal Hampshire County Hospital in Winchester provided general, medical and surgical care for children and young people up to and including the age of 18.

The service comprised the inpatient Northbrook Ward with18 beds (recently reduced to 12 open beds due to staffing shortages), six beds were allocated for day surgery. There was a Paediatric Assessment Unit (PAU) called Sophie's Place, a day surgery unit (covering ENT, Eye clinic, dental and oral maxilla-facial surgery) and an outpatients department.

There was a level two Neonatal Unit (NNU) with 12 cots for babies who require short term intensive care. This comprised two intensive care unit (ITU) beds, two high-dependency (HDU) bed and eight special care cots for babies who required additional support. The majority of older children who required level three, one to one intensive care were transferred to Southampton and Oxford hospitals via the retrieval team.

Young people over the age of 16 were given the choice of receiving care on the paediatric or adult wards. Children with specialist requirements for example oncology were cared for on the paediatric ward and receive their intensive chemotherapy on Piam Brown Paediatric Oncology ward at UHS. End of life care is supported by Naomi House Hospice.

During the inspection, we visited all areas of the paediatric service excluding the intensive care unit (ITU). We talked to nine families, four children and 26 members of staff. This included support workers, play specialists, nurses, senior managers, senior clinicians and the clinical lead. We observed care and looked at 15 records relating both to patients and the running of the service. Before our inspection reviewed performance information from and about the trust's services for children and young people.

Services for children and young people

Summary of findings

We rated services for children and young people services as 'good' for providing safe, effective, responsive and well-led services. The service was outstanding for caring.

Incidents were reported and appropriately investigated. Lessons were learnt to support improvements. Staff had an understanding to be open and transparent when things go wrong and the new regulation of Duty of Candour was being followed. Clinical areas were visibly clean and staff were following infection control procedures. Medicines were appropriately managed and stored and equipment was available and regularly tested to be fit for use.

Staff took steps to safeguard children. Children's risks were appropriately assessed and procedures were followed to identify if their condition might deteriorate. Children with mental health problems were, however, not being assessed and supported by mental health professionals in a timely way.

Action was being taken to ensure safe nurse staffing levels. Consultants were covering middle grade doctor vacancies but this practice was not sustainable in the long term

Care and treatment was based on national guidance and evidence based practice. The services was monitoring clinical standards and participated in local and national audits. The trust scored better than the England average for diabetes and asthma outcomes.

Children and young people had good pain relief, nutrition and hydration. The hospital had received the level 3 "Baby Friendly" Accreditation in the neonatal unit in 23 July 2015 which supports parents to be partners in care.

Staff had appropriate training and were highly competent. Staff worked effectively in multi-disciplinary teams and with external providers to provide a holistic approach to care. The hospital, however, did not have sufficient inpatient paediatric physiotherapists to effectively support patients with cystic fibrosis.

Seven day services had developed for medical staff and consultants were available seven days a week.

Staff were providing a compassionate and caring service. Feedback from people who use the service, those who are close to them, was overwhelmingly positive. Children and their parents spoke of staff going "above and beyond" to provide care and keep them well informed, and of an "excellent" service. Children and their parents were involved in their care and treatment . Play leaders supported children to understand their care and reduce anxiety.

The service was being planned around managing service demands and responding to the needs and preferences of children, young people and their families. There was good access to the service, with open access for children with chronic conditions and those who had recently been discharged. There were good link with the community child health team, based in the hospital, leading to continuity and an integrated care approach. The service was meeting the needs of children with long-term chronic and life-limiting conditions by working in collaboration with other hospitals and hospices.

The trust needed to work with its partners to ensure there was a service level agreement for children and young people with mental health needs. There was support for children with a learning disability.

Governance processes appropriately managed quality and risks issues, although we did not see how risks were being escalated to the trust board. Staff were positive about the local leadership of services and demonstrated they were passionate and committed to delivering high quality, patient focused care.

There was evidence of cross site working, for example, to streamline services and share good practice although it was acknowledged that more work was required to develop consistent service across the trust.

Children and young people were encouraged to feedback ideas to improve the service.

Services for children and young people

Are services for children and young people safe?

Good

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

We rated safe as 'good'

Incidents were reported and appropriately investigated. Lessons were learnt to support improvements. Staff had an understanding to be open and transparent when things go wrong and the new regulation of Duty of Candour was being followed. Clinical areas were visibly clean and staff were following infection control procedures. The infection control standards on the Northbrook Ward had been identified and action as an area for improvement. Medicines were appropriately managed and stored and equipment was available and regularly tested to be fit for use.

Staff had an appropriate understanding of how to safeguard children. They took steps to prevent abuse from occurring, respond appropriately to any signs or allegations of abuse and worked effectively with others to implement protection. However, not all staff has been appropriately trained.

Children's risks were appropriately assessed and procedures were followed to identify if their condition might deteriorate. Children with mental health problems were, however, not always being assessed and supported by mental health professionals in a timely way. The local CAMHs provided assessment if children and young people were inpatients. Following assessment, if there was the need for additional nursing support, this was provided by nursing agency, to provide1:1 care to keep the young person and other inpatients on the unit safe from harm.

The service had vacancies for nursing staff and junior and middle grade doctors. Nurse staffing levels were meeting standards as cover was being arranged with staff from across the paediatric unit, and the trust had closed beds on Northbrook ward. Consultants were providing additional medical cover but this practice was not sustainable in the long term.

Incidents

- Between May 2014 and April 2015 here had been four STEIS (Strategic executive information system) "Serious Incidents" recorded across the trust. Between January and July 2015, two serious incidents had been reported on Northbrook paediatric in-patient ward. We reviewed the trust investigation report and action plan into both of these incidents which showed that the incidents had been investigated and learnt from.
- Staff knew how to recognise and report incidents using the trust electronic reporting system. All the incidents reported for the child health service (November 2014 to April 2015) were low or no harm incidents
- Staff followed processes to report incidents on the trust's electronic reporting system, and these were investigated and lessons learnt. Incidents, complaints and significant events were discussed at forums such as clinical governance meetings then fed back to staff at ward meetings. Incidents were used at staff training sessions to help improve practice.
- Safety performance was monitored through monthly management meetings. This information contributed to senior management meetings where data was collated on the trusts incident reporting system. The data was analysed to identify trends, newly presenting risks and those requiring escalation to the trust's risk register. Individual patient's cases were risk assessed and rated accordingly to alert staff to children whose situation/ presentation presented a higher risk to their health and safety. Information considered included incidents and accidents occurring during work activities and safeguarding concerns. We saw evidence of action plans resulting from these meetings and the corresponding changes in practice.
- Actions had been taken following incidents. For example, to make Northbrook Ward a safer environment for young people with mental health problems, ligature points had been removed in the adolescent area. The protocol and risk assessment policy for Children and Adolescent Mental Health (CAMHs) patients had been updated, laminated and displayed for staff to follow.
- We were made aware of two incidents where children who had required mental health support following their admission did not have immediate support through the CAMHS team. We saw the completed incident forms and noted that actions and learning points had been

identified. The ward sister told us an outcome from this incident had resulted in the current development of a risk list tool which staff would complete at the child's admission. This tool has been ratified

- Staff told us they felt they would receive feedback and support from their managers and team members where this was necessary and told us all incidents were used as learning tools for the future. We saw files with incidents which had been reported and the learning outcomes.
- The 'Duty of Candour' regulation states that providers must be open and honest with service users and other relevant persons when things go wrong with care and treatment.
- Most clinical staff we spoke with knew about 'Duty of Candour' and demonstrated knowledge of what this new regulation involved. However, we observed that a few junior medical staff had not been aware of this new regulation.
- The 'Duty of Candour' was being applied. We saw evidence within action plans which confirmed outcomes of investigations had been shared with the families concerned.

Cleanliness, infection control and hygiene

- All clinical environments and communal areas were visibly clean.
- Equipment was visibly clean and labelled as clean.
- The areas we visited had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance and wall mounted hand hygiene gels. There were signs reminding staff and visitors to use hand hygiene gel to sanitise hands at admission to the unit and wards.
- The environmental audit of the Northbrook Ward (April 2015) showed overall non-compliance (below 95%) with infection control standards. There was an action plan to address areas for improvement.
- Staff had received infection prevention and control training as part of their annual essential training programme. Trust training statistics confirmed that 92.5% nursing staff in acute paediatrics and 94.1% of paediatric medical staff had completed infection control training in 2014.
- We observed staff adhered to the infection control policies, including 'bare below the elbows', hand hygiene and appropriate use of personal protective equipment, such as disposable aprons and gloves.
- Infection control audits had been completed in 2014, including hand hygiene and 'bare below the elbow' audits. The feedback report (February 2015) identified that the neonatal unit hand hygiene audit scored 100% compliance. Northbrook in-patient paediatric ward, outpatient department and Sophie's place also scored 100% compliance with their weekly and monthly hand hygiene audits for February 2015.
- Northbrook ward has seven cubicles which were used for cohorting or isolating children and young people with enteric illness or suppressed immune systems as required.

Environment and equipment

- The specialist paediatric surgical department is located in Southampton. However minor and routine surgical procedures take place in general theatre with paediatric allocated days and times. Children and young people stay on Northbrook paediatric inpatient ward. There were no young people on any adult ward at the time of inspection.
- There were adequate supplies of equipment suitable for babies, children and young people in all clinical areas. We undertook random checks on the resuscitation equipment and syringe drivers. We saw that emergency trolleys were appropriately stocked and sited. They contained a range of paediatric appropriate equipment including cannulae, airways and defibrillator pads.
- On Northbrook paediatric ward, we saw that syringe drivers had PAT test stickers on some of which were out of date. We discussed this with the sister who showed us the electronic maintenance logs. It was clear that all equipment had ward been tested and was in date. The estates maintenance department was called to update the stickers.
- To help maintain a safe environment, access to areas where children were cared for were secured by a swipe card and buzzer controlled entry system.
- A robust risk assessment undertaken on Northbrook ward had recommended anti-ligature door locks, however, these had not yet been installed. Ligature points had been removed on the adolescent ward.

Medicines

- The trust's electronic prescribing system had led to an incident of antibiotic Gentamycin being administered late on the neonatal unit. As a result a flow chart was devised using National Institute for Health and Care

Excellence guidelines (NCG 149 Early Onset of Sepsis) in conjunction with pharmacy and microbiology. New doctors entering the trust were given training on the flow chart and the prescribing of IV Gentomycin and Benzyl-penicillin.
- The trust policy for safe management of medicines was in line with National Institute for Health and Care Excellence (NICE) guidance.
- Children who were admitted with their own medicines were seen by the on-call pharmacist who checked logs and verified medication then secured it in the drug cupboard. Pharmacists also visited wards to clarify and check stock daily. At the time of the inspection we did not see parents administering their own child's medication.
- We noted that medications were securely stored across all areas we visited. For example, medicines were stored in locked cupboards. Controlled drugs were stored in accordance with NICE safe storage guidelines. Drug keys were kept separate from the ward keys.
- Medication fridges were at the correct temperature, and temperature logs confirmed that fridges were regularly checked.
- We reviewed seven medication charts and no gaps were seen against entries. We noted that children's allergies and weights had been clearly added. We did not observe medication being administered during the inspection.

Records

- We reviewed 15 sets of medical and combined multidisciplinary team (MDT) nursing notes both on the electronic system and hand-held child records.
- The care records were standardised and covered relevant assessments of care needs and risk assessments. Records were complete and accurate, easy to understand and up to date. The electronic system contained entries from the multi-disciplinary team. All records were reviewed were in line with the Nursing and Midwifery Council guidance on record keeping.
- Patients were weighed and their height measured. Observation charts, paediatric early warning systems (PEWS) and fluid charts were completed and totalled. High dependency observation charts were completed for higher risk patients.
- Records showed daily review of patients by consultants and clear management plans.
- The five steps to safer surgery checklists were completed for children and young people who had undergone surgery.
- The care plans we saw were patient focused and showed clear evidence of parents and children being involved in decisions about their care.
- Records were stored securely on the electronic recording system and for hand-held notes were checked.
- An audit of electronic care records was conducted on a monthly basis. Compliance with standards was high and action was identified for ensuring notes were appropriately signed. Issues arising were addressed with resultant actions disseminated to the staff through the ward meetings.
- Changes to the electronic discharge summaries meant that paediatric clinicians now had to complete lengthy discharge summaries which were adult focused. This has been identified as a risk on the risk register and an appropriate discharge summary was being developed.

Safeguarding

- All staff we spoke with showed in depth understanding of safeguarding and what was required of them with regard to reporting concerns. There were clear policies and procedures in place which included working with external agencies.
- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- Staff told us they had effective working relations with the local children's safeguarding and child protection teams and demonstrated a knowledge of what to do and who to contact should a concern be raised.
- Paediatricians routinely reviewed the records of children who missed appointments. GP, community services and the safeguarding team were notified where there is concern that a child may be suffering neglect. Routine bi-monthly reviews of children were made for those of concern by safeguarding team and paediatricians.
- Staff had access to the joint safeguarding and child protection registers.
- NICE safeguarding guidance recommends that qualified staff should be trained to a level 3 in children's safeguarding. The trust Safeguarding Children Annual Report (April 2015) identified that 72% of staff had been appropriately trained to level 1, 73% to level 2, and 71% to level 3.

- All staff on the on the paediatric assessment unit had been trained to level 3. Staff told us that most nursing staff had completed the training. We spoke to three junior doctors who had yet to complete the training. Courses were available and there were on-going training sessions.
- There was policies around safeguarding and domestic abuse which included Female Genital Mutilation (FGM). There were clear flow charts in place for reporting suspicions. In 2014 the safeguarding children team received 1,867 forms compared to 1,134 in 2013. The trust identified the increase in activity positively reflected frontline staff recognition of vulnerability and risk in the presentation of children and parents or carers.
- The trust met the statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the trust underwent a DBS check prior to employment, and those working with children had undergone an enhanced level of checking.

Mandatory training

- We talked with members of staff of all grades and confirmed they had received a range of mandatory training and training specific to their roles. For example incident reporting, paediatric resuscitation, health and safety, medicines management and information governance.
- The trust's training figures for 2014 confirmed that 94.1% of medical staff and 92.5% of staff in acute paediatrics had completed mandatory training.
- The neonatal nurses were 89% compliant with paediatric basic life support training with some members of the nursing team having achieved the "New born life support (NLS) qualification". This course specifically teaches the skills and knowledge of airway support and resuscitation of the new-born child.

Assessing and responding to patient risk

- Clinical areas used their own risk assessment tools. A red flag system was used to highlight patients of concern. This including children who condition might deteriorating children. These were based on incident triggers risks and children were escalated against their individual risk protocols.
- The 'Paediatric Early Warning Score' (PEWS) was a system used to monitor children and to ensure early detection of physical health deterioration. PEWS observation charts for children of different ages clearly identified when observations were outside the normal range and actions to take for different scores. Staff told us they would escalate concerns to medical staff. We reviewed five paediatric early warning score observation charts and found these had been completed.
- Critically unwell children were escalated to the medical team who liaised with the family, ITU and outside agencies for example the Southampton and Oxford retrieval team to obtain the best possible treatment.
- In the day surgery unit staff had briefing meetings prior to surgical procedures. This briefing review included a review of the individual patient, their weight to calculate anaesthetic medication, a check on instruments required emergency drugs in the anaesthetic room and extra set of emergency drugs. The unit worked in partnership with Southampton hospital regarding provision of children under 1 year old.
- Following a change in the way Child and Adolescent Mental Health Services (CAMHS) were commissioned, the service had continuing problems in gaining timely access to mental health services for patients. There had been incidents where security staff and mental health staff had been assaulted by young people with mental health problems and vulnerable young patients had absconded from the ward. Security staff and porters told us incidence of abuse were occurring more frequently. There had been a serious incident of attempted hanging in January 2015. The incident had been investigated and the trust had adopted most of the risk assessment recommendations from the serious incident review, although recommended anti-ligature door locks had yet to be installed on Northbrook Ward.
- Guidelines for young people admitted as a result of self-harm had been agreed and developed with the local child and adolescent mental health services (CAMHS). This included better risk assessments for young people who self-harm.
- There trust now had a policy on "patients who abscond from the clinical environment" and a "missing persons" policy. Both included a risk assessment tool and advice such as "when to call the police".
- There had not been any young people admitted with mental health problems during our inspection. However, hospital data indicated there were long delays between 4 – 12 hours for an appropriately trained Registered Mental Health Nurse (RMN) to assess CAMHS patient's and provide care.

Services for children and young people

Nursing staffing

- Royal college of nursing guidelines for paediatric wards state there should be a minimum of 70:30 registered to unregistered staff with a higher proportion of registered nurses in areas such as children's intensive care, specialist ward. There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas and at least one nurse per shift trained in each clinical area trained in advanced or European paediatric life support There should be access to a senior children's nurse for advice at all times throughout the 24 hours period.
- The children's wards had used national guidelines, professional judgment to identify planned staffing levels. Information supplied by the trust indicated there were nursing shortages across most departments. In order to meet staffing requirements, staff were shared with the paediatric assessment unit (PAU) and day surgery unit and with staff from Basingstoke and North Hampshire Hospital as required.
- The ward sister on Northbrook paediatric ward told us they had lost six beds due to staffing shortages. The ward capacity had gone from 18 beds to 12. Staff shortages were being managed by cross sharing of Paediatric trained staff from Basingstoke. Agency staff were not used.
- Staffing rotas for the week of 22 – 28 June demonstrated that there was always a minimum of two registered nurses at all times on Northbrook and at least one trained nurse. The trust planned staffing was 75:25 registered to unregistered staff. Overall this was being achieved at night but was not achieved during days and evening shifts. However, the ratio was only slightly lower than the recommendation at 67:33.
- There was a band 7 sister which covered the day surgery unit at both Winchester and Basingstoke. The unit was staff by the sister and three other registered nurses and one healthcare assistant. On Mondays there were 17 patients per list for ENT, Eye clinic, dental and oral maxilla-facial surgery . On alternative Wednesday there were 4 cases per list for general surgery.
- The neonatal unit met the British Association on Perinatal Medicine (BAPM) safe staffing guidelines and were at full establishment. Their staffing levels were matched against dependency scores (BAPM NNU dependency levels) with a red flag system and had the ability to "Flex" (bring in more staff) according to need. Extra staff were accessed from the neonatal units specific bank of nurses who were familiar with the unit and had had specific training.
- The neonatal unit ran a 12 month rotational preceptership training for newly qualified staff to ensure that staff were fully skilled in all areas.
- Northbrook paediatric ward were using agency RMN's to provide the care for CAMHS patients. CAMHS services were being provided by a local mental health trust. However, delays in assessment meant that agency staff were being used.
- All nursery nurses and play specialists working throughout the hospital were qualified within their speciality.

Medical staffing

- Information supplied by the trust indicated that at September 2014 the medical staffing skill mix across the trust was rated at 58 whole time equivalents (WTE). 31% consultants, 8% middle career (doctors who have worked for at least three years as a senior house officer (SHO) or above. 56% Registrars and 5% junior doctors within their foundation year 1-2. The medical staffing mix for the trust was in line with the England average statistic. However, the service currently had difficulties recruiting junior doctors, and was seven junior and middle grade doctors under complement
- Medical staffing met The Royal College of Paediatrics and Child Health (RCPCH) guidelines for medical staffing for acute paediatric patients. There were allocated consultants for covering acute services out of hours and weekends in general paediatrics. All paediatric inpatients were seen by a paediatric consultant within 24 hours of admission. Paediatric consultants were on site up to 10pm with on call consultant cover out of hours and over the weekend. The medical team were on-site 24 hours a day, seven days a week.
- The junior doctors told us they were well supported by consultants and registrars, including out of hours. The shortage of middle grade doctors meant that consultants were working at a lower level to cover clinics and additional shifts to ensure a safe service.
- There were two anaesthetic consultants with paediatric specialist interest. There was an anaesthetic consultant or intensive care specialist available out of hours to provide anaesthetic and analgesic advice and support for children's services.

- The neonatal unit was staffed by three consultant neonatologists. There was a RCPCH-compliant medical rota that provided 8am to 10pm consultant presence on the unit and on-call cover.
- In the Winchester Treatment Centre, there were always two anaesthetists for each paediatric list. This allowed them to deal with emergency issue such as airway spasm and for the safety of patients. Recovery nurses were all trained in paediatric resuscitation at level two and were supported from staff from the paediatric wards as needed.
- We observed one paediatric handover and saw there were thorough records of which doctors' had attended and clear clinical instructions documented. Medical staff told us teaching took place at handover sessions three times a day; two sessions were consultant led.

Major incident awareness and training

- There were established arrangements in place with agreed actions for staff to take if a major incident was declared.
- The trust had a business continuity plan which ensured that critical services could be delivered in exceptional circumstances.
- A trust major incident policy (dated 2015) was in place. This policy identified what measures would be put into place should a major incident require paediatric expertise.
- The neonatal unit had contingency planning in place for when the neonatal unit was at full capacity or in bad weather conditions. Escalation guidelines were also included in this document.

Are services for children and young people effective?

Good

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

We rated effective as 'good'

Care and treatment was based on national guidance and evidence based practice. The services was monitoring clinical standards and participated in local and national audits. The trust scored better than the England average for diabetes and asthma outcomes.

Children and young people had good pain relief, nutrition and hydration. The hospital had received the level 3 "Baby Friendly" Accreditation in the neonatal unit in 23 July 2015 which supports parents to be partners in care.

Staff had appropriate training and were highly competent. Staff had regular supervision and annual appraisals. Staff worked effectively in multi-disciplinary teams and with external providers to provide a holistic approach to care. The hospital, however, did not have sufficient inpatient paediatric physiotherapists to effectively support patients with cystic fibrosis. Therapy assistants were supporting the service but there were occasions when children did not get physiotherapy.

Seven day services had developed for medical staff and consultants were available seven days a week.

Evidence-based care and treatment

- The trust's hospital protocols were based on NICE and relevant Royal College of Paediatrics and Child Health (RCPCH) guidelines. Local policies were written in line with these and had been kept up to date.
- We saw examples of national guidance being followed including National Institute of Health and Care Excellence (NICE) guidance for "care of early onset sepsis" on the neonatal ward and compliance with level three "Baby Friendly Initiative" for breast feeding.
- The Bliss for "Babies born too soon" neonatal toolkit which outlines eight principles for high quality neonatal services was being adhered to.
- Assessment and treatment given was in line with British and Irish Orthopaedic Society guidance and care interventions based on the latest NICE and Special Educational Needs and Disability (SEND) guidance for children with complex needs.
- There was audit programme for child health for the year 2014/15. Of the 16 projects identified across the trust's, the hospital was involved in six. The majority of audits were completed or in progress. There was some evidence that learning from clinical audits was shared across the trust. Examples of audits completed at RHCH included record keeping and weight audit in paediatric

and neonatal admissions. The audit had been completed with an action plan for improvements. The allergy team conducted regular patient audits and these views are acted on. For example the audit led to the yearly follow-up appointments system being offered.

Pain relief

- We observed an age appropriate, Lego faced, child friendly pain assessment tool was in use. This helped identify and manage pain in children. A pain assessment chart was readily available in each patient's clinical records.
- Some pain relief, such as paracetamol suspension was given by nursing staff under Patient Group Direction (PGD). This enabled qualified nursing staff to administer up to three doses without the need to be prescribed by a doctor.
- There was access to an anaesthetist 24 hours a day seven days per week to advice on paediatric pain relief.
- Parents were positive about the pain management for children. For example, we spoke to a parent who told us the pain relief for their child had been highly effective. Their child had come into A&E screaming in pain. Within 10 minutes of arrival, the child was on the paediatric ward pain free and calm. The parent told us they could not have expected a better service.

Nutrition and Hydration

- The hospital had achieved the "Baby Friendly" Accreditation level three in the neonatal unit on 23 July 2015. The Baby Friendly initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding' and to practise in accordance with the International Code of Marketing of Breast Milk Substitutes. Stage 3 for neonatal services assesses whether parents have been supported to have a close and loving relationships with their baby, that they are valued as partners in care, and that babies are enabled to breastfeed/receive breastmilk when possible
- The NHS Information Centre performs an 'Infant Feeding Survey' every five years. The figures from the 2010 survey were published in November 2012. The 2010 figures showed some significant improvements from the 2005 survey. Two of the key findings showed that the proportion of babies' breastfed at birth in the UK rose by 5%, from 76% to 81%. The data is historic but at that time the initial breastfeeding rate in 2010 for the hospital was highest in England at 83%.
- A variety of age and culturally appropriate food choices were available to children both during the day and night. This also included a wide selection of age appropriate snacks.
- Facilities were available for parents to prepare their own food and beverages.

Patient outcomes

- The children's service participated in all the national audits for which it was eligible. These included paediatric diabetes, paediatric asthma, and peanut allergy, behaviour of pre-school children, paediatric record keeping and safeguarding of children audits.
- The trust scored better than the England and Wales average for two measures in the Paediatric Diabetes Audit 2013/14 for individuals having controlled diabetes with the Royal Hampshire County Hospital scoring 19.4% against the England average of 17.1%.
- Re-admission rates for asthma, diabetes and epilepsy for 1-17 year olds across the trust were higher than the England average with diabetes being at 25% over 10% higher than the England average of 14.6%.
- The National Neonatal Audit programme (NNAP) 2013 reported the Royal Hampshire County Hospital had met or exceeded three out of five standards required in the audit. They fell slightly below the standard for 85% of mothers receive any dose of ante-natal steroids and 100% of eligible babies should receive first retinopathy of prematurity screening in accordance with national guidelines. The hospital scored 84% and 97% respectively.

Competent staff

- The neonatal nursing team were qualified in speciality (QIS) according to recommendations of the "toolkit for High Quality Neonatal Services" (DOH 2009). The team was achieving 70% trained nursing staff and 80% QIS. Newly qualified nurses rotated within the network one year preceptorship programme.
- Student nurses gave us very positive feed-back saying they felt fully supported throughout their placements. Regular training sessions were held with regards to respiratory conditions, diabetes and oncology and were

available for all staff to attend. However staff told us that meetings tended to happen on the Basingstoke site with no teleconferencing facilities available which had led to staff at Winchester often being unable to participate.
- The NHS national staff survey figures showed that 81% of staff across the trust had received appraisals within the previous 12 months. The annual staff appraisal matrix was seen for Northbrook paediatric ward which showed only four staff were outstanding.
- Staff told us they received regular monthly supervision sessions and were encouraged to speak to their line managers earlier if any problems arose.
- In the General Medical Council (GMC) National Training Scheme Survey 2015, the trainee doctors rated their overall satisfaction with training as similar to other trusts.

Multidisciplinary working

- Staff reported that they had seen an improvement in the way in which they were working across the two main acute hospital sites in the trust.
- The hospital had close links with "Naomi House" the children's hospice and had joint training sessions on how to manage paediatric "end of life care".
- The neonatal ward worked closely with the maternity and A&E departments. They offered telephone advice or would attend either department to help with unwell babies where required.
- There was a transition pathways in place for patients with diabetes.
- Children and adolescent mental health services (CAMHS) provision had previously been provided by the trust but was recommissioned and was now provided via partnership with mental health trusts in Sussex. Staff identified working relationships between CAMHS professionals and the paediatricians needed to improve. There were in delays obtaining assessments for children and young adults who attended the A&E department with mental health problems.
- The trust currently had insufficient numbers of paediatric physiotherapists available to provide chest physiotherapy to children with Cystic Fibrosis (CF) whilst in-patients during the week in the hospital and at weekends across the trust. The adult physiotherapy team did not have the resources to offer support, and this did not meet care service standards. Paediatric physiotherapists were being support by therapy assistants to provide levels of support and new physiotherapy on-call guidelines were to be circulated. However, the business case submitted to cover extra resources was not able to be funded. Staff were now completing incident forms for every incident when paediatric physiotherapy was not available for children with CF. This situation was impacting on staffing and they had lost members of the paediatric physiotherapy team and their expertise.

Seven-day services

- Consultant paediatric and neonatal staff worked weekends from 8am to 5pm.
- The paediatric and neonatal consultant provided 24 hour support. Rotas were available to inform staff which paediatricians were available with contact details. Medical and nursing staff said they could access consultants out of hours and described the consultant team as supportive.
- Staff said they could access out-of-hours investigations, for example imaging and urgent laboratory tests. We were told pharmacy access and support was available via an on-call system.
- There was a multi-agency safeguarding hub responsible for co-ordinating out of hour's enquiries.

Access to information

- All clinical areas had trust policies and procedures available which were accessible to staff on the trust's intranet.
- Discharge summaries were being completed for GPs and the majority of these were done within 48 hours, with only a few delays. Discharge summaries for day cases are done on the same day.

Consent

- We spoke with staff confirmed that patient consent would be sought prior to any procedures or tests being undertaken. Children and parents we spoke with told us they had been involved in decisions relating to the treatment offered to them.
- We observed consent procedures in the paediatric out-patient department. Consent procedures were appropriate. As part of one preoperative child's journey both the surgeon and anaesthetist explained the procedure, checked the parents and child's

understanding of the procedure and confirmed that written consent had been obtained. We observed nurses gaining appropriate verbal consent prior to taking blood tests on Northbrook Ward.

Are services for children and young people caring?

Outstanding ☆

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

We rated caring as 'outstanding'

Staff were providing a compassionate and caring service and this was embedded in the ethos and culture of the service. Feedback from people who use the service, those who are close to them, was overwhelmingly positive. Children and their parents spoke of staff going "above and beyond" to provide care and keep them well informed, and of an "excellent" service. Feedback on the service had been provided in picture format so that children could understand.

Staff had developed a person-centred culture. Staff were motivated to offer care that was kind, supportive, and open. Staff were committed to work in partnership with children's and their parents. Children and their parents were involved in their care and treated and were encouraged to ask questions. Play leaders supported children to understand their care and reduce anxiety through the use of story books and dolls.

Emotional support was offered to children and their families. Children's emotional and social needs were highly valued by staff and was embedded in their care and treatment. Staff used age appropriate communication and had received training to support children and their families with chronic and terminal illness.

Compassionate care

- We observed many examples of compassionate and understanding care being delivered by friendly, approachable and committed staff.
- We spoke with six parents, three relatives and four patients who all told us they had received compassionate and thoughtful care and advice. Without exception, they identified that staff had put the children at the centre of their care.
- We heard and saw written examples of extremely positive comments from parents, relatives and children who used the service. Comments included mention of staff going above and beyond to make people feel comfortable, welcome and well informed. Others described the service as an excellent ward and hospital.
- Parents told us they were able to accompany their children to theatre and recovery areas and were informed by ward staff when their children were out of theatre so they could re-join them to help lessen anxieties.
- The feedback from children on Northbrook ward was overwhelmingly complimentary about the care they had received from the doctors and nurses. For example, one child commented "I don't mind coming in here anymore I know I can still do all the things I like to do at home. The nurses are really nice and they make me laugh".
- The children's in patient survey (2014) was printed with pictures for ease of understanding at any age. The results showed that questions relating to caring scored the same as other trusts. The question related to "Do patients feel listened to" was better than other trusts. One child told "I have been in lots of children's hospitals but I like it here best".
- On the paediatric assessment unit. Staff used age appropriate communication. We observed excellent interactions between patients, consultant's nurses and parents.

Understanding and involvement of patients and those close to them

- Children and their parents told us they understood and were involved in their care and treatment and were kept updated.
- We observed children and their parents were encouraged to ask questions prior to treatments beginning.
- Play leaders explained pre-operative procedures to small children using story books showing them airways and other equipment with the use of dolls. This helped to lessen anxiety and prepared children psychologically for theatre and procedures.

- Consultants told us they focused on good communication with children and parents even when busy. We did observe this, although we also observed one consultant come into the busy waiting area and started discussing medical information with a family without offering a private space.

Emotional support

- We saw examples of nurses and doctors offering emotional support to parents and a midwife offering emotional support to a mother who was having problems expressing milk via a breast pump. The mother told us "I would not have been able to manage without the incredible support I have received from the nurses here".
- There were quiet rooms available away from the main ward area where parents could go to get away from the ward environment. There was a room used for breaking bad news. Although on one occasion we observed one consultant come into the busy waiting area and started discussing medical information with a family without offering a private space.
- Staff on Northbrook paediatric ward and the neonatal unit worked closely with Naomi House Hospice and attended training sessions on how to support families of terminally sick children and how to break bad news.
- Counselling services were available to parents and bereavement and chaplaincy support was offered where required.
- There were information on support groups for specific conditions such as Cystic Fibrosis. Staff encouraged and supported children and parents to link into these groups.
- A LEGO brick Model, designed by a play leader at Basingstoke and North Hampshire Hospital, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension.

Are services for children and young people responsive?

Good

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

We rated responsive as 'good'.

The service was being planned around managing service demands and responding to the needs and preference of children, young people and their families. There was good access to the service, with open access for children with chronic conditions. There were good link with the community child health team, based in the hospital, leading to continuity and an integrated care approach. The service was meeting the needs of children with long-term chronic and life-limiting conditions by working in collaboration with other hospitals and hospices

Information was available for children and their families although written information was only available in English. Translation and interpreter services were available. The trust needed to work with its partners to ensure there was a service level agreement for children and young people with mental health needs. There was support for children with a learning disability.

Complaints were handled appropriately in line with trust policy and these were reviewed to improve the service.

Service planning and delivery to meet the needs of local people

- There was evidence of service planning to manage service demands. The inpatient Northbrook Ward had recently reduced bed numbers from 8 beds to 12 open beds due to staffing shortages,
- The Paediatric Assessment Unit (PAU) called Sophie's Place, was helping to reduce the volume of children seen in community and in the ED. For example, Sophie's Place undertakes all immunisations of babies with mothers who are admitted to Melbury Lodge mother and baby unit so that bloods can be taken by paediatric

trained nurses. Sophie's Place also runs a blood clinic for children under 3yrs so that bloods can be taken by paediatric trained nurses in a child friendly environment.

- There are direct GP referrals to a paediatrician in Sophie's Place so that children do not need to attend A&E. There is open access for children with long term conditions to Sophie's Place. Parents can call to say their child and they are triaged to either Sophie's Place or A&E.
- Referrals to the ward or Sophie's Place could be made by ED, the community nursing team and GPs.
- Day surgery (covering ENT, Eye clinic, dental and oral maxilla-facial surgery) was done on Mondays at the Winchester treatment centre in the adult unit. Two bays out of six were converted for children on Mondays. The adult bays were separate and round the corner. Patients were pre-assessed two weeks before on a Sunday and consented on day of operation. There were 17 patients on this list. On Alternate Wednesday, patients were pre-assessed in clinics and general surgery was done in the day case unit and recovery was on Northbrook paediatric ward. There are 4 cases per list. The same nurses were used for pre-assessment clinics and in-patients wherever possible. There were two MRI lists per month with five patients per list.
- There was a level two Neonatal Unit (NNU) with 12 cots for babies who require short term intensive care. This comprised two intensive care unit (ITU) beds, two high-dependency (HDU) bed and eight special care cots for babies who required additional support. The majority of older children who required level three, one to one intensive care were transferred to Southampton and Oxford hospitals via the retrieval team.
- The service did not have a service level agreement for child and adolescent mental health service (CAMHS). Funding had been agreed with the clinical commissioning group. If a CAMHS patient required a Registered Mental Health Nurse (RMN) for more than three days, this was funded by the CAMHS. (RMN's) where booked where required were via an agency.
- Children with specialist requirements for example oncology were cared for on both the paediatric ward and at Naomi House Hospice. Children with cancer were supported through shared care with the paediatric oncology service at UHS. Staff told us they had direct access to all of the policies and procedures from the Tertiary Centre and would access these in order for a consistent approach to a child's or young person's care. Close links were in place with Salisbury Hospital. Each cancer patient had access to the ward whenever they required. Nursing staff had started a programme of oncology training to strengthen the support provided within this service.
- The community paediatric nursing team was also based in the hospital

Meeting people's individual needs

- Children were being cared for and treated in bright child friendly wards and spaces. There was a separate room for teenagers and a kitchen, rest room and sleeping facilities for parents on Northbrook inpatient paediatric ward. The Patient having day surgery on the adults wards did not have an appropriate environment, for example, toys or games for children or teenagers to use.
- Information leaflets were available on a number of health topics including asthma, bronchiolitis and urinary tract infections. These were available in both inpatient and outpatient settings. However some information leaflets were out of date as still displaying Winchester and Eastleigh NHS Trust. This could have been confusing to patients and the information no longer relevant.
- Health promotion information and access to local services was available for children and young people.
- There were also leaflets on support groups for specific conditions, for example, Cystic Fibrosis.
- Information on how to access hospital services was available for people within clinical areas or on-line via the trusts web-page.
- Most leaflets seen were available in other languages such as polish and Nepalese. This was in response to a large polish and Nepalese community. Leaflets were available in other languages via the internet.
- Staff reported there was access to interpreters and a translation service should this be required. The ward sister showed us available information to support people with different languages and cultures.
- Parents were offered tea and coffee on a regular basis.

Access and flow

- With the exception on CAMHS patients, only children up to the age of 16 could access services unless they were already known to the service and under the care of a consultant. New patients aged between 16 and 18,

would automatically be placed within adult wards and services. Young people over the age of 16 that were known to the service were given the choice of receiving care on the paediatric or adult wards.

- Patients were given the choice of which hospital - either in Winchester or Basingstoke - they wish to attend for clinical assessment.
- There was a 48 hour open access policy. This meant that should a child or young person deteriorate within this timescale once discharged they could come straight back to the service without the need for a further referral. This time frame could be extended for children with chronic or unstable conditions.
- In Sophie's Place parents told us that appointments were offered quickly with options of different days offered.
- There was not a waiting list for surgery.
- Occasionally tonsillectomy day surgery patients had to stay on the ward overnight however over 90% of patients were recovered and discharged on the same day.
- There were delays for children who presented with mental health needs and required the CAMHS service. Care for children and young people would be compromised if the staffing resources and specialist support was unavailable. Children were being assessed between four to 12 hours following a referral to the CAHMS service.
- Neonatal and children's services provided good access to its services. Children with long term conditions had open access to the paediatric ward via the "Green card" temporary open access system. The ward had a folder detailing children and young people who required open access and their notes were kept on the ward.
- Other children given access to the "Green Card" were children who had been assessed as fit for discharge home. Parents told us this had given them peace of mind knowing they could bring their child straight back to the ward without having to go through the ED if they deteriorated.
- There were good links with the paediatric community team. Referrals were made and communicated with this team in a timely manner so that consistent and appropriate on-going care could be maintained.

Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy. We noted there was clear information available within the service to inform people how they could make a compliant or contact the patient advice and liaison service (PALS).
- Complaints were discussed at the service's clinical improvement and management team meetings. Outcomes and actions were disseminated to staff through formal and informal meetings.

Are services for children and young people well-led?

Good

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

We rated well led as "good."

The service strategy was documented in plans for a new critical treatment hospital. However, staff were aware that there was no approved date for the development of this project. Current priorities focused on workforce and staffing issues. Governance processes appropriately managed quality and risks issues, although we did not see how risks were being escalated to the trust board.

Staff were positive about the local leadership of services and demonstrated they were passionate and committed to delivering high quality, patient focused care. There was an open and transparent culture to report concerns to improve care. The trust merger was seen as positive as there had been an investment in services and centralised management which created efficiencies. There was evidence of cross site working, for example, to streamline services and share good practice although it was acknowledged that more work was required to develop consistent service across the trust.

Children and young people were encouraged to feedback ideas to improve the service.

Services for children and young people

Vision and strategy for this service

- There service did not have a documented vision or strategy. However the clinical leads we spoke with were committed to trust plans for a proposed new Critical Treatment Hospital. We were told there was a "plan B" if this plan did not go forward but this was not being circulated.
- The current priorities were identified which were to address workforce and staffing at each of the trust sites, and look for improved efficiency in cost improvement plans.

Governance risk management and quality measurement

- There was a monthly child governance forum which fed into a monthly business unit performance review and divisional governance board for the family & clinical support services division. Information was fed into this meeting from trust wide Neonatal Forum, Acute/ Ambulatory Forum Community Forum, Education Forum and the Safeguarding Forum
- The governance meetings reviewed guidelines, audit, incidents and complaints, education and training, and operational and performance issues and strategy. Improvements and actions was identified and good practice was shared across the service.
- The clinical audit programme was being used to measure quality of the service and patient outcomes.
- Patient feedback was regularly assessed and reviewed and there was evidence which demonstrated actions were being taken as a result of the feedback. For example facilities for parents who needed to stay had been improved. Reclining chairs were being replaced by more comfortable pull down beds.
- The child health risk register identified key risks for the service, mitigating actions had been undertaken and most risks had been reviewed with a current description of the risk and actions taken. The highest risk (red rated) was identified as the completion of discharge summaries. Other risks included the insufficiency of the CAMHS, nurse staffing. The risks were reviewed regularly in the clinical governance meetings. We did not, however, identify from the evidence that the higher risks (red risks) were escalated to the trust's risk register to be reviewed by the trust's executive committee.
- There was a multidisciplinary approach to audit and governance within the service. Plans were in place to allocate lead roles in relation to quality and governance for senior clinicians in the service.

Leadership of service

- There was good local leadership of the service. Clinical staff felt well supported by their immediate management structure. Nursing staff told us of the many ways they had been supported locally by their ward and senior managers.
- Every member of staff we spoke with told us the leadership team within this trust had made significant improvements over the past two years.
- Staff told us that the Children's and Younger People's services had become more visible within the trust and they felt listened to. We were told of ideas that had developed within this service and been shared across other parts of the trust as areas of good practice.
- Trust members were visible. Every member of staff we spoke to could name the CEO and at least one other board member.

Culture within the service

- Our discussions with staff and managers demonstrated they were passionate and committed to delivering high quality and patient focused care.
- The NHS National Staff survey for Hampshire Hospitals showed that 75% of staff agreed they would feel secure raising concerns about unsafe care and practice. Staff told us the hospital had an open culture where the reporting of incidents when things went wrong was actively encouraged. All staff understood how this was influencing positive service change and improvement.
- Staff we spoke with told us morale within the service was reasonably good. Staff felt valued and many reported being thanked and felt appreciated for the work which they carried out. The only negative comments had been around staffing levels. However it was stated by many clinical staff that things had improved over the past two years with the introduction of staff covering both hospital sites.
- There was joint working with Basingstoke and North Hampshire hospital particularly around nurse staffing and outpatient clinics. It was acknowledged that more work needed to be done to develop joint working

practices across medical and inpatient services. Medical staff were now all based at Basingstoke and this has improved relationships, for example through joint meetings and joint discussions.

Public engagement

- We saw various initiatives in place to gain the feedback from children and young people and their families. One initiative was the "friends and family" initiative "would this be a good place for your friends and family to come to if they were ill". Children were encouraged to complete the form which included smiley faces and well-known cartoon characters to help communicate what they felt was good or bad about the service. This feedback was displayed throughout the service and via booklets "Your survey results 2014" which were available in all areas.

Staff engagement

- Staff were positive about engagement. Senior staff identified the benefits of the hospital merger and the improvement seen.
- There was joint working with Basingstoke and North Hampshire hospital particularly around nurse staffing and outpatient clinics. It was acknowledged that more work needed to be done to develop joint working practices across medical and inpatient services. Medical staff were now all based at Basingstoke and this has improved relationships, for example through joint meetings and joint discussions.
- Staff were positive about the visibility of the chief executive.

Innovation, improvement and sustainability

- Clinical directors told us they had supported the merge of both hospitals for safety and sustainability of the service. The Royal Hampshire County Hospital Winchester had received more investment and had become more effective by having specialized services on-site.
- The trust had looked at both hospitals to see where services worked best and to the benefit of patients. The management structure had been centralized which helped to improve communication and efficiency.
- There had been many improvements to the service due to the two hospitals working together. For example the sharing of good practice in outpatient clinics and nursing staff working across site and sharing if day surgery staff expertise. Community Child Health services were multi-disciplinary and integrated across trust sites. There was less evidence of shared services for inpatient paediatrics.

End of life care

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

Information about the service

Hampshire Hospitals NHS Foundation Trust serves a population of approximately 600,000 across Hampshire and parts of West Berkshire.

Between January and December 2014 there were 1,433 in-hospital deaths across Hampshire Hospitals NHS Foundation Trust.

Hampshire Hospitals NHS Foundation Trust provides end of life care services at Royal Hampshire County Hospital as part of the cancer services unit within the surgical services division.

The specialist palliative care (SPC) services forms part of the Winchester and Andover specialist palliative care service and provides specialist palliative care to the Royal Hampshire County Hospital in addition to the Countess of Brecknock Hospice (COBH) and the community of west Hampshire. All the services are NHS managed and belong to the trusts cancer services business unit within the surgical services division.

During our inspection we visited seven wards, the emergency department and the critical care unit where end of life care was provided in addition to, the bereavement centre, the chaplaincy and the mortuary. We spoke with four patients, two relatives and 24 staff, including staff nurses, health care assistants, ward sisters, members of the specialist palliative care team, porters, a member of the chaplaincy team, junior doctors, mortuary staff and the bereavement staff. We observed interactions between patients, their relatives and staff, considered the environment and looked at 18 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and six medical and nursing care records. Before our inspection, we reviewed performance information from and about the hospital.

End of life care

Summary of findings

End of life care at this hospital was "outstanding". We rated it 'good' for safe, effective and responsive services and outstanding for caring and well-led services.

End of life care at this hospital was safe and people were protected from avoidable harm and abuse. Reliable systems and process were in place to ensure the delivery of safe care.

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

Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was mostly positive and we observed many examples of outstanding compassionate care.

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

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

There was good multidisciplinary working, staff were appropriately qualified and had good access to a comprehensive training programme dedicated to end of life care. However we were concerned about the uptake of mandatory training by the specialist palliative care team.

Patient outcomes were routinely monitored and where these were lower than expected comprehensive plans had been put in place to improve. However, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were not always made appropriately and in line with national guidance.

Patient's needs were mostly met through the way end of life care was organised and delivered. However, the rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way. The specialist palliative care team identified rapid discharge as a challenge. We saw where recommendations and actions to address these audit results had been made and results had been discussed at board level.

End of life care

Are end of life care services safe?

Good

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

We rated safe as 'good'.

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

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

Medicines were managed safely and patient records were completed and stored appropriately.

Safeguarding vulnerable adults was given sufficient priority and staff could describe what safeguarding was and the process to refer concerns.

Staffing levels were sufficient to ensure end of life patients received safe care and treatment. Staff reported good access to the specialist palliative care team and there was appropriate arrangements for out of hours cover. However, the uptake of mandatory training for the specialist palliative care team was significantly below the trust target of 80% in six out of ten subject areas.

Incidents

- Incidents were reported through the trust's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- Between January 2015 and March 2015, five incidents relating to end of life care had been reported. These were patient falls and a delay or failure to monitor a patient's condition. Incidents were monitored through the cancer and radiotherapy governance services framework. This group met quarterly and was chaired by the clinical lead for end of life care. We saw, from minutes following these meetings, where incidents had been discussed. Where incidents had occurred we saw where appropriate actions had been taken. For example in the mortuary, 'on-call' arrangements had been changed to ensure staff had adequate rest between attending the mortuary 'out of hours' and their next scheduled shift.
- One incident in the mortuary, involving tissue damage to a deceased body, had been reported to the Human Tissue Authority (HTA). The HTA is a regulator set up in 2005 to regulate organisations that remove, store and use human tissue. Following this incident we were told the relative of the deceased had been contacted, an explanation was given in addition to an apology on behalf of the trust.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting system.

Medicines

- The trust had standard operating procedures for the prescribing of anticipatory medicines, medicines prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness). We reviewed six medical and nursing case notes of those patients identified as being in the last hours or days of life. We saw where anticipatory medications were prescribed appropriately.

Records

- Patients 'achieving priorities of care' (APoC) documentation was stored at the patient's bedside. This allowed for ease of access for the multidisciplinary team, patients and their relatives.
- During our inspection we saw where medical notes for end of life patients were stored securely at the nurses stations. Nursing records were accessed via an electronic patient record system and were password protected.
- We reviewed the medical and nursing notes for six patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.

End of life care

Safeguarding

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. None of the staff we spoke with were able to recall any recent safeguarding incidents relating to end of life care.

Mandatory training

- The specialist palliative care team (SPCT) reported having good access to mandatory training. The trust target for the staff uptake of mandatory training was 80%. We saw where the uptake of mandatory training for the SPCT was significantly below the trust target in the following six subject areas: infection control 58% (11 put of 19 staff); information governance 36% (seven out of 19 staff); manual handling 68% (13 out of 19 staff); basic life support 68% (11 out of 16 staff); fire safety 63% (12 out of 19 staff) and safeguarding children 68% (13 out of 19 staff).

Assessing and responding to patient risk

- We reviewed the nursing notes of six patients identified as being in the last hours or days of life. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Braden Scale. Risk assessments for patients were completed appropriately on admission and reviewed at the required frequency to minimise risk.
- Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. NEWS was used to monitor patients and initiated calls to the medical staff when required. We saw examples of care being escalated promptly when a patient's condition had deteriorated. Where there had been no immediate action taken we saw evidence of a treatment escalation plan in the patient's records. Treatment escalation plans outline the level of intervention required should the patient's condition deteriorate.

Nursing staffing

- Nursing staffing within the specialist palliative care team was four specialist palliative care nurses based in the Winchester and Andover multidisciplinary team and, four based in the North Hampshire multidisciplinary team. Nursing and medical staff we spoke with all told us they had good access to and support from, the nurses within the specialist palliative care team.
- There were no dedicated 'end of life' beds at this hospital. Patients requiring end of life care were nursed on general medical and surgical wards. Nursing staff we spoke with told us they would give priority to the care of those patients in the last hours or days of life.
- As part of the palliative care link nurse programme, the hospice had a nominated end of life champion. The end of life champion shared relevant end of life information and enabled two-way communication between the specialist teams and nurses in the clinical area in order to increase awareness of end of life and palliative care.

Medical staffing

- There were 4.0 whole time equivalent (WTE) consultants in the specialist palliative care team. This met recommendations by The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care, which states there should be a minimum of one consultant per 250 beds.
- Nursing and medical staff we spoke with all told us they had good access to and support from, the consultants within the specialist palliative care team.
- Telephone support out of hours was provided by one of four palliative care consultants, on a rotational basis, and the hospice at home service.

Major incident awareness and training

- The trust had suitable major incident plans in place. A major incident policy was in place for all trust staff and outlined how Hampshire Hospitals NHS Foundation Trust would respond in the event of an emergency (major incident). Major Incident training was included on the trust corporate Induction and in the local induction for all new staff.
- The mortuary service had a policy about how to respond in the event of a major disaster this was supported by action cards, which detailed the role of the

mortuary lead, a managing excess deaths plan and, business continuity plans which detailed how the mortuary would operate following any incident that interrupted the day to day running of the mortuary.

Are end of life care services effective?

Good

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

We rated safe as 'good'.

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

Patient's symptoms of pain were suitably managed. Patient outcomes were routinely monitored There were comprehensive plans in place to improve outcomes for patients.

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

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

Local audits demonstrated poor compliance with the implementation of the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders however; there were plans in place to raise awareness of DNACPR at local teaching sessions. During our inspection we reviewed eighteen DNACPR forms. Our review showed 40% of the forms we looked at were incomplete. They did not indicate where discussion had taken place with the patient and did not contain mental capacity assessments where a patient was recorded as lacking capacity to consent.

Evidence-based care and treatment

- Between April 2014 and April 2015, 1,886 patients had been referred to the specialist palliative care team. Of these, two thirds had a cancer diagnosis.
- Patient needs were assessed and care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness.
- NICE guidance was followed in relation to end of life care for adults. We saw where the trust had benchmarked against NICE Standards for end of life care with most quality standards met.
- A review of six medical and nursing records showed symptom control for end of life patients had been managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- All staff reported having access to the Wessex Palliative Care Handbook of clinical guidelines (2014) and felt it was a good reference should they require guidance in end of life and palliative care delivery.
- Care after death was managed in accordance with local policies and guidance from the National End of Life Care Programme and National Nurse Consultant Group (Palliative Care).
- In response to the 2013 review of the Liverpool Care Pathway the trust had developed the 'achieving priorities of care' (APoC) documentation. This document guided delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate.
- A plan for auditing the use of the APoC documentation at the trust had been designed. 10 forms from each hospital would be audited every quarter. The results would be discussed with the trust end of life strategy group. Results from July to September 2014, during the pilot stage of the APoC documentation, showed between 50% and 75% of the document had been completed appropriately. We saw where audit results

following the pilot stage demonstrated an improvement in the completion of the document in addition to, feedback from users of the document with suggestions for future development.

- The trust had trialled the use of the AMBER care bundle. The AMBER care bundle is a simple approach used in hospitals when medical staff are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery; while talking openly about people's wishes and putting plans in place should the worst happen. The clinical lead for end of life care told us AMBER had not been successful at the trust. It was felt, that the limitation of a prognosis of one to two months for AMBER did not advocate advanced care planning (ACP) discussions for all patients and as such, alternative treatment escalation plans were in place. Treatment escalation plans outlined the level of intervention required should the patient's condition deteriorate.

Pain relief

- The hospital used syringe pumps for end of life patients who required a continuous infusion to control their pain. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication, because the syringe drivers used were tamperproof and had the recommended alarm features.
- Patients we spoke with had been asked about their pain and given pain relief where appropriate at regular intervals. All staff were pro-active in managing patient's pain. We reviewed six nursing records for patients in the last days of life and saw where pain assessments were included in the 'achieving priorities of care' (APoC) documentation. Where patients had required pain relief at times other than their regular dose we saw this had been given appropriately.
- Procedures were available to guide medical and nursing staff in pain management. Additionally support was available from the specialist palliative care team. This ensured in the last hours or days of life there was no delay in responding to patient's symptoms as they occurred.
- Results from the National Care of the Dying Audit 2014 demonstrated the trust was the same as the England average for achieving the organisational key performance indicator 5: Clinical protocols for the prescription of medications for the five key symptoms at the end of life.

Nutrition and hydration

- We reviewed six nursing records for patients in the last days of life. We saw that patients were screened for malnutrition and the risk of malnutrition on admission to hospital using the malnutrition universal screening tool (MUST). Where interventions were required we saw these documented on the 'achieving priorities of care' (APoC) documentation.
- Nursing staff told us where a patient's food intake was poor, they would be seen by a dietician and supplements would be given if appropriate. We were also told that the hospital kitchen could sometimes provide alternative food. For example, a cooked breakfast was available.
- Mouth care was delivered appropriately and interventions documented in the APoC documentation.

Patient outcomes

- The hospital was contributing data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set.
- The trust had taken part in the National Care of the Dying Audit May 2014. The Trust performed better or the same as the England average for six out of the seven organisational key performance indicators (KPI) and worse than the England average for seven out of ten clinical indicators. The trust scored significantly lower than the England average for; KPI 4: Assessment of the spiritual needs of the patient and their nominated relatives or friends; KPI 6: A review of interventions during the dying phase; KPI 7: A review of the patient's nutritional requirements and; KPI 8: A review of the patient's hydration requirements.
- In response to the National Care of the Dying Audit the trust had identified eight work streams through their

end of life strategy. We saw where each work stream had an identified individual responsible for addressing and achieving those clinical indicators where performance was notably worse than the England average.

- The trust was participating in a research project led by Lancaster University. In support of this project and following a successful bid for funding from the Department of Health, the trust was in the process of recruiting 50 volunteer befrienders. The volunteers were to offer companionship to palliative and end of life patients, in their own homes. The clinical lead for the service told us the trust was the only NHS provider in England that had been accepted to be part of this project.
- There were 450 in hospital deaths between January and March 2015.The case notes of 122 (27%) of these patients were reviewed by senior doctors using the trust mortality matrix. Results from this audit were mostly positive with 87% of consultants reporting that end of life care was managed appropriately, 88% of consultants felt the patient was reviewed by a consultant appropriately and 97% of consultants felt the patient's death was unavoidable. Following this audit, areas for improvement had been identified and fed back to the relevant staff. Examples included access to medical notes and identified 'gaps' in the medical documentation.

Competent staff

- The trust had participated in the National Care of the Dying Audit in May 2014. The results showed that the trust was identified as significantly better than the national average in relation to continuing education, training and audit in palliative and end of life care.
- The palliative care education steering group met monthly to discuss end of life training at the trust. Minutes from these meetings demonstrated where training had been put in place, for example 'achieving priorities of care' (APoC) education, 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) competency training and training plans for junior doctors.
- The palliative care service supported a comprehensive internal and external training programme to improve the awareness and quality of palliative care delivered by clinical staff at the hospital.
- Four palliative care study days were held per year, two for health care assistants (HCA) and two for registered nurses. The study days alternated between two hospital sites at the trust.
- End of life and palliative care training was delivered on both medical and nursing induction days. This included input from the chaplaincy and bereavement services. At the time of our inspection some members of the specialist palliative care team (SPCT) were delivering training for the new doctors due to commence employment at the trust in August 2015.
- 'Grand rounds' took place at the trust. Grand rounds are an important teaching tool and a ritual of medical education and inpatient care, consisting of presenting the medical problems and treatment of a particular patient to an audience consisting of doctors, residents and medical students. The SPCT had, on occasions, been invited by a consultant to provide end of life training during these rounds.
- During our inspection we visited six wards where end of life care was being delivered. Across the six wards 193 registered and unregistered nursing staff had received some form of end of life training in the last 12 months.
- Porters received training around palliative and end of life care via the mortuary. Training included an orientation to the mortuary, health and safety training include manual handling and, training on the administration duties required when registering a body in the mortuary. Porters we spoke with during our inspection confirmed they had received this training.
- The SPCT had access to a range of external education courses relevant to their role. We saw where staff from the SPCT had recently attended for example, a palliative care conference, communication training and training around 'Do Not Attempt Cardio Pulmonary Resuscitation'.
- Within the specialist palliative care team 94% of staff had received an appraisal in the last 12 months.

Multidisciplinary working

- The specialist palliative care team (SPCT) worked closely with the community specialist palliative care team, local GP's and a nearby community trust to provide continuity of care throughout the patient's journey.
- A daily admissions meeting was held via video conference link between this hospital and the Countess of Brecknock Hospice. This meeting involved hospital

SPCT, nursing staff from the hospice and consultants. The meeting allowed a daily discussion of any patients requiring admission to the hospice, either from the community or from the hospital. It was also an opportunity to discuss any new referrals to the community team, hospice at home service (HAH) or SPCT who required urgent input or advice.

- The Winchester/Andover specialist palliative care group multidisciplinary team met weekly via video-conferencing facilities in the hospital and the Countess of Brecknock Hospice to discuss new patient referrals and, the care and management of existing patients known to the service.
- The trust was developing an electronic palliative care co-ordination system. Electronic Palliative Care Co-ordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care at the end of life. At the time of our inspection staff within the trust were made aware of those patients known to end of life and palliative care services through a 'tagging' system on the patients electronic care record. Key details regarding patient's preferences were shared with external providers and GP's through a twice-weekly video conference.
- Those patients with a confirmed diagnosis of heart failure, who were anticipated to be in the last 12 months of life, were referred to the cardiac palliative care clinic to be seen by a cardiac failure clinical nurse specialist and a palliative care consultant.
- An end of life facilitator supported the SPCT, working 24 hours per week over four days. The end of life facilitator managed the bereavement office, looked at concerns and comments for themes, was involved in audits specific to end of life care and, played an active role in arranging education sessions for staff.

Seven-day services

- Specialist palliative care services were provided seven days a week, 8.30-4.30pm. Out of hours telephone advice was available via the Countess of Brecknock Hospice or the consultant on call, contactable via the trust switchboard.
- Mortuary services were available 8am to 4pm seven days a week with on-call cover out of hours.
- Chaplaincy services were available to cover all three hospital sites. 10am to 6pm Monday to Friday with on-call cover out of hours.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed six medical and nursing records of patients in the last days of life. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and, patients were supported to make decisions.
- We saw one patient receiving end of life care whilst being deprived of their liberty. We saw that the deprivation of liberty safeguards and orders by the court of protection authorising deprivation of a person's liberty were used appropriately.
- A trust wide audit of DNACPR forms dated April 2015 showed 92% had a documented reason for DNACPR decision; 51% had been discussed with the patient; 84% were clearly timed, dated and signed; 96% where an appropriate person had made the DNACPR decision; 84% had been countersigned by a consultant within 48 hours; 70% had a DNACPR decision documented in the medical notes and; 54% where there was a discussion with the patient or relative documented in the notes. Following this audit we were told the trust had plans to include teaching sessions on the importance of DNACPR policy at the junior doctor's induction. A case based DNACPR presentation including case law was also to be included regularly at induction.
- During our inspection we reviewed 18 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Our review showed 10 out of 18 DNACPR forms had been fully completed. Approximately 40% of the forms we looked at were incomplete. They did not indicate, in the medical notes, where discussion had taken place with the patient and did not contain mental capacity assessments where a patient was recorded as lacking capacity to consent.

End of life care

Are end of life care services caring?

Outstanding ☆

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

We rated caring as 'outstanding'

We observed a strong, person-centred culture. Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients and their families were consistently positive and included many examples of where staff had gone "above and beyond". Mortuary staff prepared relatives before viewing a deceased body, This would include explaining what the body may look like or an explanation of any marks or discolouration on the body. Porter staff told us they would transport a deceased body as if it were a member of their own family and, on Anthony Letchworth ward staff were caring for a dying patient and their relative who was also an inpatient at this hospital.

Staff valued and respected the totality of both, patients' needs and the needs of their families. We saw where patients' emotional, social and religious needs had been taken into account and were reflected in how their care was delivered. Staff on the wards would be alerted to an end of life or deceased patient through the use of a poster of a butterfly. Butterflies on stems were also positioned at the nurses station.

All staff were committed to providing compassionate care not only to patients but also to their families and post bereavement. Patients and their families were truly respected and valued as individuals and were empowered as partners in their care. There was good access to the trust chaplaincy service for patients and their families. Emotionally, relatives were well supported by staff at the hospice, the specialist palliative care team and, the chaplaincy department. Where relatives required further support, additional support was made available via external bereavement and counselling services.

Compassionate care

- The trust had participated in the National Care of the Dying Audit in May 2014. The results showed that the trust was identified as better than the national average in relation to the provision of care that promoted patient privacy, dignity and respect, up to and including after the death of the patient
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Medical and nursing staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- Mortuary staff told us they prepared relatives before viewing a deceased body, This would include explaining what the body may look like or an explanation of any marks or discolouration on the body. Mortuary staff offered body viewings seven days a week up to 9pm. Out of hours viewings did not normally take place for in-patients however mortuary staff told us this could be arranged if required, for example, if a 'sudden death' had occurred. Mortuary staff told us their proudest moment was knowing a deceased body had been cared for respectfully and with dignity.
- Porter staff saw end of life care as an important part of their role. They told us they would transport a deceased body as if it were a member of their own family and recognised the importance of treating the body with dignity and respect.
- The bereavement service supported the hospital to provide a sensitive and specialised service when a patient died. The bereavement officer had been in post for many years and had dedicated their self to provide a holistic and person centred caring service, often working beyond paid hours to support the needs of bereaved relatives. The bereavement service were involved in the immediate period following death and provided practical help and information to deceased relatives. In addition, the bereavement service officers supported the process to obtain consent for a hospital post mortem examination.
- On the critical care unit we observed caring and compassionate care, with nursing and medical staff developing an effective, close and caring relationship with a patient who was in the last hours of life and their relative. The patient looked calm and comfortable.

End of life care

- Within the emergency department staff responded compassionately to those patients identified as being in the last hours of life. These patients were moved to a quieter area of the department in order to respect the privacy and dignity of the patient and their relatives.
- On Anthony Letchworth ward a patient had been identified as being in the last days of life. The patient's relative was also an in-patient at this hospital. Nursing staff told us the couple had been together for 80 years and as such staff were providing care to both patients in the same side room. On the day of our inspection we saw the consultant responsible for the relative's care come to the ward to review their patient.
- Staff recognised and respected the emotional needs of relatives. We saw where staff on the wards would be alerted to an end of life or deceased patient through the use of a poster of a butterfly. Butterflies on stems were also positioned at the nurses station. Staff told us this was a reminder to staff to maintain a calm and peaceful environment whilst end of life care was being delivered on the ward. It was also useful to inform those staff not regularly present in the clinical area that a patient was receiving end of life care or had died.
- We spoke with four patients and two relatives during our inspection. Feedback was mostly positive about the way staff treated patients receiving end of life care. However, one relative expressed concerns about the responsiveness of the medical and nursing staff. The relative felt the nursing staff were focussed more on the acutely unwell patients present on the ward. We observed an interaction between a nurse and this patient and we viewed care which we all agreed was exceptional and far beyond that expected. Whilst we were on the ward talking with this relative the ward sister had contacted the specialist palliative care team to review the patient and then approached the relative to discuss their concerns.

The trust collected information on the quality of end of life care. A questionnaire was given to relatives in person when they visited the bereavement team to collect the patient's death certificate. Between January and March 2015 there were 240 deaths at this hospital, of these 40 questionnaires had been given out with a response rate of 17%. Results showed; 97% of people felt their relative was sometimes or always treated with respect and dignity; 95% of people felt their relative sometimes or always had enough privacy and; 97% of people reported that their relative or friend was always looked after well.

Understanding and involvement of patients and those close to them

- The trust had participated in the National Care of the Dying Audit in May 2014. The results showed that the trust was identified as worse than the national average in relation to health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying. The survey also identified the trust as worse than the national average for communication regarding the patient's plan of care for the dying phase. This did not reflect what we saw during our inspection.
- On the critical care unit we observed the consultant and key members of the nursing team explaining to a relative the results of a patient's recent tests and the recognition that the patient was in the last hours of life, the achieving priorities of care (APoC) documentation was also discussed before being put in place. We spoke with four patients during our inspection. All had been identified as being in the last 12 months of their life. All four patients spoke positively about the care they had received at this hospital. They felt staff had explained their care and treatment to them in a way they could understand. One patient told us they were very happy with their care and described it as "first class".
- Communication training, based on the 'Sage and Thyme' model was provided for all staff. The 'Sage and Thyme' model provided evidence based communication skills training to all levels of staff and gave a structured and quick approach for dealing with the concerns of patients and their family.

Emotional support

- Staff on the wards offered emotional support in addition to the specialist palliative care team. The trust also had a chaplaincy service and counselling services if required. Support for carers, family, friends and hospital staff was provided by the chaplaincy and bereavement services.
- Nursing staff reported good access to the chaplaincy department. They knew members of the chaplaincy team by name and said a member of the team would visit the wards at any time. A member of the chaplaincy

team visited the wards on a Saturday to determine which patients would like to attend the chapel on Sunday for prayer. Where patients were unable to attend the chapel prayers would be delivered at the patient's bedside if requested. At all other times during the week the chaplaincy team told us they would be mindful to patients and/or relatives distress. Where people did appear distressed they would offer comfort if required.

- Between six and eight weeks following a patient's death a bereavement card, signed by the trust chief executive, would be sent to the patient's family. Bereavement evenings were held three times a year on each of the three hospital sites. A counsellor from the specialist palliative care team would be in attendance. Where additional bereavement support was required contact numbers for external bereavement counselling services would be offered.

Are end of life care services responsive?

Good

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

We rated responsive as "good".

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

The hospital delivered patient centred care in a timely way. Patients were reviewed by the specialist palliative care team within 24 hours of a consultant referral. The hospice at home service played an active part in ensuring treatment and support was available to patients and their families 24/7.

The needs and preferences of patients and their relatives were central to the planning and delivery of care with most people achieving their preferred place of care/death. However, the lack of side rooms throughout the hospital meant patients in the last hours of life were sometimes nursed on 'open' wards. This was distressing for the patient and their relatives and could be distressing to other patients.

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

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

Service planning and delivery to meet the needs of local people

- There were no dedicated end of life beds at this hospital. Patients identified as being in the last days or hours of life were mostly nursed on general medical and surgical wards. Nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. This was not always possible and was dependent upon the patient capacity on the wards. Most staff, nursing and medical, told us there was a shortage of side rooms. The clinical lead for the trust told us they recognised there was a shortage of side rooms at this hospital. In order to ensure the privacy and dignity of those patients identified as being in the last hours or days of life and nursed in a bay with other patients, the butterfly initiative had been introduced.
- The 'achieving priorities of care in last days and hours of life' (APoC) pathway documentation was commenced when the patient was recognised to be likely to be in their last days or hours of life. Advanced care planning was included in this document. We reviewed six APoC documents and saw where the patients preferred place of care/death had been documented.
- Between January and March 2015 there were 451 inpatient deaths across this hospital and Basingstoke and North Hampshire Hospital. Of these, 27% of patients were on the APoC pathway and 20% on this pathway had been asked their preferred place of death. In total 62% of patients asked, had died in their place of choice. This was better than the average cited by The

National Survey of Bereaved People 2014 (VOICES – Views of Informal Carers – Evaluation of Services), who state "only half of the deceased who wanted to die at home actually died there".

- Information about the needs of the local population was collected quarterly to inform the commissioners how services were planned and delivered. Information included; the number and percentage of patients who died with an end of life care plan; the number and percentage of patients who wished to die at home and who did not achieve this and; an analysis of barriers as to why patients were not supported to die in their preferred place of choice.
- The hospice-at-home (HAH) service was an integrated community service that delivered care to those patients identified as being in the last days or hours of life. Care was provided from 10pm until 8am seven days a week by trained and untrained nurses from the Countess of Brecknock Hospice. Between January and May 2015 the HAH had been funded by commissioners of the service. At the time of our inspection the service was being funded by the trust whilst a decision regarding further funding was being made by the commissioners.
- From January to May 2015 there had been 46 referrals to the HAH service. Reasons for referral included administering of injections for pain relief, assessment, reassurance, verification of death and night support. Outcome data about the HAH service demonstrated a positive impact on other services with 13 hospital admissions prevented, 12 hospice admissions prevented and, a 98% reduction in out of hours visits by GP's.

Meeting people's individual needs

- The needs and preferences of patients and their relatives were central to the planning and delivery of care at this hospital. The hospital was flexible, provided choice and ensured continuity of care. The cardiac palliative care clinic ran monthly to see those patients with a confirmed diagnosis of heart failure who were anticipated to be in the last 12 months of life. The aims of the cardiac palliative care service included patient involvement in clinical decision making; to reduce unnecessary hospitalisation; to identify and improve achievement of preferred place of death; to provide and maintain optimum symptom control; to improve quality of life; to provide and signpost to appropriate psychosocial support and; improve communication between all services and professionals involved in patient's care. 35 patients had been seen at the cardiac palliative care clinic between April 2013 and August 2014.
- 'Just in case' medication (JIC) leaflets were given to patients, relatives and carers when the patient was discharged from the hospice. This included information regarding medicines that the patient would be discharged with. JIC medicines are medicines that may or may not be needed, but are kept in the patients home 'just in case' they need it one day.
- Bereavement packs included written information for bereaved family and friends. Specific leaflets for children of the deceased were available at the hospice and through the bereavement service. Nursing staff told us leaflets could be made available in languages other than English if required.
- Interpreting services were available. Staff demonstrated a good awareness of the language needs of the local community and told us the process they would follow should they require an interpreter.
- The spiritual needs of patients were identified in the achieving priorities of care (APoC) documentation. This meant patients and their relatives could access chaplaincy services in a timely manner. The reverend told us where patients or relatives had requested faith leaders from other religious denominations, or their own faith leader, this would be arranged by the chaplaincy service.
- A 'free' car parking space was allocated to bereaved families who were due to meet with bereavement services. Bereavement staff told us this helped to alleviate any anxieties the family may have about returning to the hospital. Free car parking for those families visiting patients identified as being in the last days or hours of life was also available and arranged by the end of life facilitator. Information about car parking services was available in the end of life resource box located in each ward area.
- Bereavement services would meet with bereaved families to arrange collection of the patient's death certificate in addition to arranging a viewing at the mortuary if required. Where post mortem arrangements were in place this would be explained to the family.

Access and flow

- Patients had timely access to the specialist palliative care team (SPCT). Between March 2014 and February

2015 audit results demonstrated 100% of patients had been seen within 24 hours of a referral being made to the SPCT. We reviewed six medical and nursing records of patients in the last days of life and saw where the patient had been seen within 24 hours of a referral to the SPCT.

- We received mixed feedback regarding fast track discharges. Fast track discharges take place when a patient has a rapidly deteriorating condition and is considered to be in the terminal phase of their illness. Nursing staff told us 'fast track' discharges could take between one and four days to arrange and how quickly the patient was discharged home depended upon how quickly continuing healthcare funds could be authorised and, the level of care the patient would need. The National Framework for NHS Continuing Healthcare and NHS funded nursing care was published in 2007 and revised in 2012. This framework states people with a rapidly deteriorating condition should be "fast tracked" to receive NHS funded care in a place of their choice at the end of their life.
- The hospice at home service was able to provide short-term care to support an earlier discharge.
- Nursing staff told us rapid discharge for those patients in the last days or hours of life could usually be arranged within 24 hours. Rapid end of life discharge documentation was available to provide guidance to the nursing staff. Copies of the document were placed into the end of life resource box available on all of the ward areas.
- A retrospective audit of all patients discharged, from either this hospital or the Countess of Brecknock Hospice, to their home under continuing health care 'fast track' funding was undertaken between March 2014 and March 2015. The National Framework for NHS Continuing Healthcare and NHS funded nursing Care (2012) standards are that 100% of patients referred to the specialist palliative care team (SPCT) for assessment of suitability of fast track funding are assessed within 24 hours and, 90% of patients whose preferred place of death is at home are discharged within 48 hours of assessment with the correct level of care. Results from the audit showed 100% of referrals for 'fast track' assessment were seen and assessed by the SPCT within a 48-hour time frame and, the average time from sign off to discharge was consistently between four and five days. We saw where these results had been discussed at the end of life strategy group meeting in May 2015. It was agreed at this meeting that, whilst most discharges were subject to delays outside the control of the trust, data would continue to be collected and, results shared at this meeting.

Learning from complaints and concerns

- Between April 2014 and March 2015 the trust received 606 formal complaints, of these, four related to end of life care at this hospital. Complaints were taken seriously and mostly responded to in a timely way. We saw, in all four complaints, where an apology had been given. Improvements were made to the quality of care as a result of the complaints. For example, the education given to staff involved in delivering end of life care had been updated to include; more detailed information on how to deal with patient's agitation and an update on the procedure for issuing a death certificate outside of bereavement office working hours.
- The clinical lead for end of life care was proactive in managing and learning from concerns and complaints. We were told where individual complainants would be contacted to ask if they would partake in a patient story teaching session. This had been delivered at the trust both as a taped recording and through a face-to-face session with nursing and medical staff and the complainant.
- The trust collected information on the quality of end of life care. A questionnaire was given to relatives in person when they visited the bereavement team to collect the patient's death certificate. The end of life facilitator for the trust was responsible for collating the results of this survey and discussing with individual teams at ward level to ensure shared learning could take place.

Are end of life care services well-led?

Outstanding ☆

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

We rated well-led as "outstanding".

The strategy and supporting work streams and objectives of end of life care at this trust were stretching, challenging

and innovative. We saw where these were also achievable. An end of life strategy group promoted the end of life care agenda and advised the trust board on any future plans for end of life care. Representation from other services within the trust included elderly care and emergency medicine.

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

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

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

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

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

Vision and strategy for this service

- The trust's strategy for end of life care was "Living as well as possible, until you die", supported by the CARE values. Staff on all the wards we visited were aware of the strategy and supported and demonstrated the trust values. The trust had identified eight work streams in order to ensure end of life care was delivered in accordance with this strategy. These included care in the last days and hours of life; care planning at the end of life; enhanced co-ordination of care; do not attempt cardio-pulmonary resuscitation decisions; care after death; organ donation; culture: communication: patient and Carer experience and end of life education.
- The trust had an end of life strategy group chaired by the clinical lead for end of life care. The purpose of this group was to promote and drive the end of life care agenda forwards and advise the trust board on any future plans for end of life care. Meetings were held bi-monthly and included representation from other services within the trust including elderly care and emergency medicine. Minutes of these meetings demonstrated a strong focus on governance arrangements in end of life care with discussions around the 'achieving priorities of care' (APoC) documentation, rapid end of life discharge, the bereavement survey and a review of complaints relating to end of life care. This group fed into the surgery services governance board.
- The trust specialist palliative care service met quarterly with a multidisciplinary attendance from doctors, allied health professionals, specialist palliative care nurses and representatives from the social work department. Minutes from these meetings demonstrated a shared responsibility towards end of life care at the trust. Examples of items discussed included, seven-day working, the use of sedation and, education and training. Where actions had been identified at these meetings, we saw where these had been completed.

Governance, risk management and quality measurement

- Staff received monthly health and safety bulletins. These were used to keep staff up to date with failures in equipment, processes and procedures. We saw where sharps management, waste management and online learning management had been included in these bulletins.
- There was an effective governance framework to support the delivery of the end of life strategy at this trust. Quality, risks and performance issues within end of life care were monitored through the cancer and radiotherapy governance services framework. This group met quarterly and was chaired by the clinical lead for end of life care. We saw, from minutes following these meetings, where a wide range of issues were covered including audit activity and results, patient feedback, staff training and finance.

End of life care

- We saw where there were good working arrangements with commissioners and third party external providers. The clinical lead for end of life care met quarterly with the Wessex palliative and end of life care network board. Membership included palliative care leads and consultants from surrounding trusts, with representation from local clinical commissioning groups and county councils. The purpose of the group was to standardise and ensure best practice in the planning of palliative and end of life care across the Hampshire region. Consultants from the specialist palliative care team also represented the trust at the North and West Hampshire Clinical Commissioning end of life groups and the Wessex Palliative Medicine Physicians Group.
- There was not a separate risk register for end of life care. Risk registers were organised by business unit and division. The cancer services unit, which included end of life care, and surgical services division registers did not include any risks concerning end of life care. In the mortuary, which formed part of the family and clinical support services division, a risk had been identified due to a shortage of bariatric trays and the size of the bariatric fridges. Mortuary staff had identified this as a risk because the bodies they were receiving in to the mortuary were now much larger and an incident had occurred previously as a result. We saw where this risk had been included on the divisional risk register and actions were being taken.

Leadership of service

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

Culture within the service

- We saw effective team working on the wards and an obvious mutual respect amongst staff. All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. We observed staff working well together and could see staff were supportive of each other.
- Staff were clearly committed to providing good end of life care at this trust. The 'starfish' campaign, a quality improvement project relating to end of life care, was designed to encourage staff to write about small changes they were making to make a difference to patients and staff. Trust wide four examples relating to end of life care were received during March and April 2015. At this hospital a member of staff had given a patient dietary information and cooking tips and had written that the patient felt very supported and grateful for their time and effort.

Public engagement

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

Staff engagement

- Nursing staff told us of weekly emails from the chief executive (CEO). These were information-giving emails that updated staff on changes and developments within the trust. As part of the email there was an email link to the CEO. This allowed staff to anonymously contact the CEO if they had concerns about their service.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through a national award scheme. 'WOW' nominations were received either from staff working at the trust or, from the public. We saw where individual staff and the hospice team as a whole had received either nominations or awards as part of this initiative.

Innovation, improvement and sustainability

- All staff within end of life services demonstrated a strong focus on improving the quality of care and people's experiences through a range of local and national audits, feedback questionnaires and, public involvement in teaching across the trust.

End of life care

- The end of life resource boxes were a practical solution to ensure clinical staff had easy access to the right information needed to support the care they were delivering and, complimented the support of the specialist palliative care team.
- Audit results throughout end of life care demonstrated a proactive approach to continuous learning and development of the service.
- Recognition of staff through the WOW awards led to high levels of staff satisfaction throughout the service. Staff felt valued by the trust and motivated to provide a good service to end of life patients.
- Information received before the inspection and following discussions with the clinical lead for end of life care, demonstrated the strong commitment the board of directors had to this service.

Outpatients and diagnostic imaging

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

Information about the service

Royal Hampshire County Hospital is part of Hampshire Hospitals NHS Foundation Trust and provides outpatient and diagnostic imaging services for a wide range of medical and surgical clinics.

Outpatient appointments were available from 8:30am to 5pm, Monday to Friday. In 2014, the outpatient department provided 166,194 new outpatient appointments and 141, 030 follow up appointments.

The diagnostic imaging department was open for appointments from 9am to 5.00pm and offered plain film radiography, MRI, CT, ultrasound, fluoroscopy, Interventional radiology and breast imaging. The service was available 24 hours a day for emergency radiology.

During the inspection we visited the outpatient department and diagnostic imaging services as well as the breast unit and the outpatient therapy unit. We spoke with 31 patients and 40 members of staff including, nurses, consultants and other medical staff, physiotherapists, radiographers, occupational therapists, health care assistants, administrators, receptionists and managers.

Throughout our inspection we reviewed trust policies and procedures, staff training records, audits and performance data. We looked at computerised records and online booking systems. We attended focus groups and listening events, looked at the environment and at equipment being used. We observed care being provided.

Summary of findings

We found the outpatients and diagnostic departments at RHCH were outstanding for caring and good for responsive services. The service required improvement to provide safe and well-led services.

Staff were encouraged to report incidents and the learning was shared to improve services. There had, however, been one serious incident requiring investigation of a patient lost to follow up in outpatients where clear actions had not been taken to mitigate future risks. Some of the equipment used in outpatient had not been regularly tested to ensure it was safe to use.

Staff compliance with mandatory training was good in diagnostic imaging but more outpatient staff needed to complete mandatory training.

Radiographer worked alone overnight and was responsible for covering all plain film X-rays for the main hospital and the emergency department as well as basic computerised tomography (CT) scans. Radiographers reported a heavy workload and raised manual handling issues. Between 10.00pm and 8am, radiology was supported by an overnight outsourced radiologist service. Staff identified delays in the process to authorise request and provide advice on imaging which meant delays in the patient diagnosis.

Outpatients and diagnostic imaging

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

The environments were visibly clean and staff followed infection control procedures. Medicines were appropriately managed and stored. Patients were assessed although, Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used. Patients were assessed and observations were performed, where appropriate. However, there was not a tool in use to identify patient's whose condition might deteriorate. In interventional radiology there was evidence of the WHO checklist being completed and patient protocols in place

Nurse staffing levels were appropriate as there were few vacancies. There was an ongoing recruitment plan for nurses and radiographers.

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

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

Staff provided outstandingly good, compassionate care, and ensured patients and relatives were well-supported whilst in the department. We were informed of some exceptional compassionate care for patients, with nurses and radiography staff going the extra mile and far above and beyond of that expected. Patients were well-informed and routinely involved in the planning of their care and treatment. Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans. The feedback from patients and relatives we spoke with was overwhelmingly positive, within very detailed conversations.

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

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

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

Governance processes required further development in the outpatient and diagnostic department to monitor risks and quality.

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Nursing staff did not identify a strong leadership presence in the outpatient department and did not feel well supported. Radiographers felt well

Outpatients and diagnostic imaging

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

There were however, few examples of local innovation and improvement to services. In diagnostic imaging, a staff representative role was being introduced following to support and implement positive changes within the department that staff members themselves had recommended. Public and patient engagement occurred through feedback such as surveys and comment cards.

Are outpatient and diagnostic imaging services safe?

Requires improvement

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

We rated safe as requires improvement.

Staff were encouraged to report incidents and the learning was shared to improve services. There had, however, been one serious incident requiring investigation of a patient lost to follow up in outpatients where clear actions had not been taken to mitigate future risks. Some of the equipment used in outpatient had not been regularly tested to ensure it was safe to use.

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Between 10.00pm and 8am, radiology was supported by an overnight outsourced radiologist service. Staff identified delays in the process to authorise request and provide advice on imaging which meant delays in the patient diagnosis.

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

Infection control processes had been followed. The environment was visibly clean and well maintained, with all clinical areas providing hand-washing facilities and hand gels for patients and staff. The resuscitation trolleys were checked daily and staff followed procedures to ensure that all equipment was in date.

Medicines were secured correctly and patient group directions (PGD), which allow trained non-medical staff to prescribe medicines, were in date where used appropriately. Staff were appropriately trained, and had a

good understanding of, safeguarding procedures. When children were seen within the department, there was a member of staff who had attained level three in paediatric safeguarding.

Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used Patients were assessed. However, there was not a tool in use to identify patient's whose condition might deteriorate. In interventional radiology there was evidence of the WHO checklist being completed and patient protocols in place.

Nurse staffing levels were appropriate as there were few vacancies. There was an ongoing recruitment plan for nurses and radiographers.

Incidents

- In outpatient clinics and diagnostic imaging services, incidents were reported on the trust electronic reporting system. Staff felt confident with the process for reporting incidents and confirmed that feedback was disseminated during team meetings, to share learning and improve patient outcomes.
- There had been two serious incidents requiring investigation (SIRI) reported at the Royal Hampshire County Hospital between May 2014 and April 2015. The first incident involved a patient who was 'lost to follow up in 2011' and had presented in 2015 following a further referral with visual loss caused by glaucoma. This may have been prevented if the patient's annual follow up appointment had been maintained. The second incident involved an outpatient whose condition had deteriorated significantly due to delayed diagnosis of an MRI scan. Both of these incidents were subject to a full investigation using root cause analysis and were reported on at the trust serious event review group (SERG). The trust told us that learning from these incidents had been shared across all sites.
- We asked the outpatient services for information regarding patient cancellations and follow up appointments. This information was not recorded by speciality and the information was not available to confirm how many patient cancellations were appropriately followed up and how long, any patient had to wait for follow up. The service leads for outpatient confirmed that this information was still being developed. There were still no safeguards in place to ensure patient's follow up appointments were maintained and the risk of health deterioration mitigated.
- In diagnostic imaging, reportable incidents around ionising radiation medical exposure (IR(ME)R) were reported to the trust's radiation protection team and to the Care Quality Commission under IR(ME)R guidelines. Radiographers told us that there was an open reporting culture in relation to incident reporting and that their line managers encouraged staff to report incidents where applicable. Between March 2014 and February 2015 the trust had reported incidents to the Care Quality Commission. The trust was not an outlier for diagnostic imaging, nuclear medicine or radiotherapy. The number of reports was within the expected range and was similar to other trusts when compared with the same level of activity.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within ten days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principle aim is to improve openness and transparency in the NHS.
- Staff did not have a clear understanding about Duty of Candour. There was no specific training offered to staff in relation to Duty of Candour. However, there was on line guidance to follow. Staff could identify the need to be open and transparent about the care patients received and said they would raise any issues.

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic imaging areas were visibly clean.
- In the outpatient clinic there was no evidence of cleaning audits, infection control processes being followed and handwashing audits within the department. There was an infection control team within the trust who visited departments and provided feedback in infection control performance. There were no notice boards in outpatient waiting areas and this information was not on public display.

Outpatients and diagnostic imaging

- In diagnostic imaging, the hand hygiene audits reflected 100% compliance and outcomes were displayed on notice boards within the department.
- In all clinical areas there was good evidence of personal protective equipment (PPE), such as gloves and aprons being available and used appropriately by staff.
- Handwashing facilities were available in all clinical areas and hand gels were provided for staff and patients in all communal and clinical areas.

Environment and equipment

- The environment in outpatients and diagnostic imaging was well maintained
- In the outpatient department, managers told us that there were lists detailing all of the equipment within the department and when it was due for a maintenance check. However this could not be located. We looked at 17 pieces of equipment. The portable appliance testing were not all in date, with some equipment, including a blood pressure machine having last been tested in 2009. Two separate weighing scales had been checked in 2013 and 2014 respectively and had been failed. These two machines were still being used in clinic rooms. When this was raised with managers, we were told that even though they had been failed, they could still be used. However, there had not been a risk assessment to demonstrate this.
- There was appropriate access to resuscitation equipment in each clinical area
- The resuscitation trolleys in outpatients and diagnostic imaging had been checked daily and all the equipment was observed to be in date.
- In diagnostic imaging there was signage to alert patients to potential radiation hazards in relevant areas.
- Radiation protection check on equipment had been done every six months.

Medicines

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

Records

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

Safeguarding

- All staff within diagnostic imaging had completed their level 2 safeguarding training. In outpatients the up-to-date completion of safeguarding training was sporadic. Where children were seen within the department, for example in ENT or audiology, there was a clinician available who had completed their level 3 paediatric safeguarding, usually from one of the children's wards.
- Staff knew how to report safeguarding concerns. They knew where to go for further advice on the trust intranet if required.

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

Mandatory training

- Mandatory training included; infection control, health and safety, fire safety and safeguarding. Training was available as e-learning online and within a face to face classroom environment.
- Mandatory training was booked on the trust electronic system. Staff referred to the 'red, amber, green' colours which alerted them when their mandatory training was due to be renewed. Staff were able to book into available training slots and told us that they had no difficulty in being given time off to complete mandatory training.
- Line managers were alerted when a member of their team was on a 'red' colour for their mandatory training, which meant a subject was imminently due for renewal. This enabled them to monitor staff compliance with their mandatory training requirements.
- In outpatients, senior staff could not identify the percentage of those staff having completed their mandatory training. A chart was available on a notice board, that showed some staff having completed mandatory training, but this was incomplete. The low compliance with mandatory training had been identified on the outpatient and health records risk register.
- Mandatory training across diagnostic imaging was up to date with a 95% compliance rate. The trust target being 80%.

Assessing and responding to patient risk

- All staff understood the procedure to follow should a patient collapse or become acutely unwell in the outpatient or diagnostic imaging departments.
- In the outpatient and diagnostic imaging departments, Staff were told us that they would look at a patient's vital signs and record them in their notes. We observed that assessments and observations, where necessary, were recorded in the notes. The department did not use a tool, for example, the national early warning score, to identify patient's whose condition might deteriorate.
- Within the imaging department, patients were alerted by signs and information in waiting areas where radiation exposure would be taking place. There were also signs and posters to remind women who may be pregnant to inform the radiographer before their x-ray.
- There was a Radiation Protection team and a Radiation Protection Supervisor to provide advice and ensure the requesting of X-rays is in line with IR(ME)R guidelines.
- In interventional radiology a thorough risk assessment process was followed. Prior to the procedure commencing, the clinician used the WHO safety checklist to address all key clinical risks within the environment, with clear patient protocols in place.
- Staff referred to the Royal College of Radiologists standards for the administering of intravascular contrast.

Nursing/radiography staffing

- In the outpatient department there were nine registered nurses and 26 healthcare assistants. There were two vacancies, one for a registered nurse and the other for a health care assistant. Recruitment was underway to fill these posts.
- Bank staff were used to fill gaps in staffing. Induction was thorough. New bank staff were initially supernumerary, and had to complete a competency checklist before being able to work unsupported in clinical areas. No agency staff were used.
- In diagnostic imaging, staffing was a concern. There were six radiographer vacancies across the trust. Staff reported heavy workloads. Incident trends in May and June 2015 identified staff shortages to be the main cause of concern. A diagnostic imaging recruitment plan had been implemented and submitted to HR and finance.
- A radiographer worked alone overnight in the emergency department. The shift commenced at 4.00pm and finished the next day at 8.00am. Until 5.00pm there was an additional radiographer and a radiologist available off site between 5.00pm and 9.00pm. However, after 5pm, the remaining radiographer became a lone worker. They were responsible for covering all plain film X-rays for the main hospital and the emergency department, as well as basic computerised tomography (CT) scans. Where more complex scans were necessary, an additional radiographer was available on call from home. Radiographers told us that the workload was high and raised manual handling issues. Consultant radiologists and senior nursing staff told us that the considered the current practice was not safe for staff.

Outpatients and diagnostic imaging

- Diagnostic imaging services offered student radiographer placements and they had previously recruited graduates who had been students within the department.

Medical staffing

- Senior nursing staff told us that there were adequate levels of consultant cover for all outpatient clinic specialities.
- Consultant appointment times were allied to clinic times. The outpatient department opened was generally opened from at 8am to 6pm with appointments from 8.30am to 5pm.
- There were nine consultant radiologists working at the Royal Hampshire County Hospital and they were able to sub specialise. Consultants confirmed good working relationships with junior doctors within the trust.
- A radiologist was available on site between 9:00am – 5:00pm and on call/ off site between 5:00pm – 10:00pm. After 10:00pm, radiology support was outsourced overnight to a private provider. The provider could be contacted by telephone to authorise imaging and to discuss any issues with the radiographer or trust physicians as required. Radiologists, radiographers and ED staff raised concerns about this service. For example, if a CT scan was required, the emergency department (ED) doctor would need to contact the outsourced radiology support service to authorise the image. The radiographer would then be contacted by the radiology service to ask them to complete the scan. Radiographers and ED staff both noted a lengthy delay between when the request was initially made, to when the radiographer was alerted by the outsourced radiology service. The delay was up to two hours at times. Radiographers also reported delays in the provision of advice. This had and could continue to cause a delay in the diagnosis of patients who were potentially very unwell. The out of hours radiology service had been raised on the electronic reporting system as cause for concern and trends showed this was one of the most common incidents reported.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

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

There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in cardiology, ophthalmology and the breast unit. Radiography staff told us that they followed the Royal College of Radiology standards to obtain a patient's renal function status prior to administering intravascular contrast. There was evidence of local and national audit, for example, in the breast unit and within interventional radiology with practice changed and patient outcomes improved as a result.

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

There was good evidence of multidisciplinary team (MDT) working practices. Particularly in the breast unit and in cardiology. In the breast unit they were participating in an innovative clinical trial in relation to intraoperative radiotherapy.

Seven day outpatient services were not available. Diagnostic imaging provided a 24 hour services for X-ray and CT scans overnight and at the weekends

Some had an understanding around consent procedures and interventional radiology were using good clinical

protocols and comprehensive consent documentation. However, in the outpatient department, there was little understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests. The trust did not provide any specific training in relation to this.

Evidence-based care and treatment

- Outpatient services took account of relevant National Institute for Health and Care Excellence (NICE) guidelines to treat patients. We reviewed the clinical guidance for cardiology, ophthalmology and the breast unit. They all referred to NICE guidance.
- Radiography staff told us that guidelines from the Royal College of Radiology, in relation to obtaining a renal function test prior to administering contrast, had been adhered to. Evidence was seen to corroborate this.
- In interventional radiology there was evidence of good clinical protocols. There were comprehensive examples of specialist consent forms in place, which were observed being used in everyday practice.

Patient outcomes

- The breast unit is a fully integrated service which operated from the Royal Hampshire County Hospital and the Basingstoke and North Hampshire Hospital. The unit participated in national audit. For example, the National Cancer Intelligence Network Audit, the Breast Cancer Clinical Outcome Measures (BCCOM) audit and the National Breast Reconstruction audit.
- The breast unit provided data for the Somerset Cancer Registry database which was linked to the two week wait clinic auditing. As a result of evidence gained from the two week wait audits, the breast unit had changed practice to improve outcomes for patients, by providing an extra clinic to meet demand. The unit had also participated in peer review.
- The breast unit was involved in an innovative clinical trial at the Royal Hampshire County Hospital. Equipment purchased from a patient legacy, was being used to trial intraoperative radiotherapy. The outcome of this has yet to be published. The unit were awaiting NICE guidelines in relation to this.
- In interventional radiology, there was evidence of participation in local and national audit, which included the interventional pathway audit, gonad shielding and infection control.
- The follow up to new appointment rate for RHCH ranged from 2.0 to 2.2 ; the rate for England was 2.4 (January to December 2014)

Competent staff

- Some staff had completed an annual appraisal and documentation was shown to confirm this. There was no evidence or explanation why annual appraisals had not all been completed.
- There was no evidence that staff had formal clinical supervision.
- All staff across outpatients and diagnostic imaging services felt that there were good opportunities to develop professionally by being offered training to update their skills and knowledge relevant to their post. Training was also available for staff who wanted to specialise, for example in diagnostic imaging, radiographers were offered training to cover MRI and CT scanning.
- The trust encouraged a 'grow your own' ethos in relation to staff development. For example, health care assistants in outpatients told us that they had been offered the opportunity to study to become registered nurses. In cardiac physiology, students in their first, second and third year were due to join the department. This was a new 'grow your own' initiative in conjunction with Southampton University.
- Radiography students told us that the training within the interventional radiology team was 'fantastic'.
- The Outpatients department had recently been accepted to provide placements for student nurses.
- Nursing staff were generally aware of the requirements for revalidation and what their responsibilities were. They had received some information from the trust in relation to this.

Multidisciplinary working

- All nursing staff across the outpatients department told us that they had good working relationships with the consultants from each speciality. They felt that on-going communication with medical colleagues improved a patient's experience within the department.
- In the breast unit, one stop clinics were held. Staff told us that the multidisciplinary team (MDT) worked well. Nurses, radiographers, surgeons, radiologists and

oncology specialists worked together to ensure that patients received the best possible care and treatment. Documentation confirmed well supported MDT meetings.
- Evidence of good multidisciplinary working practices was observed in the cardiac catheterisation laboratory. Radiographers, nurses, cardiac physiologists and medical staff worked well together to ensure a seamless service for patients.
- In cardiology an MDT meeting was held monthly to look at case audits. Evidence was seen of good multidisciplinary attendance at these meetings. Weekly echocardiogram meetings were also held with all echo tests being reported on.
- In diagnostic imaging, staff told us they felt well supported by the radiologists. They felt part of a team where everyone recognised individual contributions to be important in ensuring that patients were given the best possible treatment.

Seven-day services

- Outpatient appointments were offered Monday to Friday 8:30am – 5:00pm.
- In diagnostic imaging, appointments were available Monday to Friday between 9:00am – 5.00pm.
- One radiographer was available overnight and at weekends for inpatients who required plain film X-rays and computerised tomography (CT) scanning. This service was also available for patients visiting the emergency department.
- A radiologist was available on site between 9:00am – 5:00pm and on call/ off site between 5:00pm – 10:00pm. After 10:00pm, radiology support was outsourced overnight.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some had an understanding around consent procedures and how patients should be supported in every day practice. There was good evidence of consent being sought and comprehensive consent documentation being used in interventional radiology.
- Staff did not have a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, to ensure decisions were taken in a person's best interest. There was no specific training provided by the trust in relation to this

Are outpatient and diagnostic imaging services caring?

Outstanding ☆

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

We rated caring as outstanding.

There is a strong, visible person-centred culture that was embedded within the outpatients and diagnostic imaging teams. We observed overwhelmingly positive interactions between nurses, radiographers, medical staff and their patients. All staff clearly enabled strong, supportive relationships with patients and their relatives.

All patients provided consistent examples of having experienced a very high standard of care from staff across outpatients and diagnostic imaging services. We were informed of exceptional compassionate care with staff going the "extra mile" and "above and beyond" of what would be expected. During inspection, we observed compassionate, caring interactions from nursing and radiography staff. There were excellent examples of staff supporting and comforting patients who were distressed.

Chaperone signs were displayed in waiting areas and staff were observed asking patients respectfully if they required a chaperone during their consultations to protect their dignity. Staff knocked on door and waited for a response before entering.

Outpatients and diagnostic imaging

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

Staff demonstrated a real understanding of supporting patients who were distressed or in physical discomfort and took time to provide the additional care that these patients required. Staff demonstrated good communication skills and were anticipating the needs of patients who might have been anxious or in distress, rather than waiting for patients to voice concerns. There were quiet rooms available for patients who had been given bad news and the trust chaplaincy service was available if required.

Compassionate care

- There is a strong, visible person-centred culture that was embedded within the outpatients and diagnostic imaging teams. We observed overwhelmingly positive interactions between nurses, radiographers, medical staff and their patients. All staff clearly enabled strong, supportive relationships with patients and their relatives.
- Patients and their relatives gave us examples of exceptional compassionate care for patients, with nurses and radiography staff going the extra mile, far above and beyond of that expected. For example one patient told us,' the staff here are amazing, they really care about you and are consistently good across the board'.
- Patients who were arriving for outpatient appointments were greeted warmly and this continued throughout their stay within the department. During our inspection the feedback we received from patients and the interactions we observed of care being provided was extremely positive throughout.
- We watched staff assisting people. Staff approached people rather than waiting for requests for assistance, asking people if the needed assistance and pointing people in the right direction.
- Staff treated patients with dignity and respect, recognising individual patient's needs. For example, we observed a vulnerable patient who was extremely distressed being cared for by a radiographer in a very sensitive manner. It was at night and the radiographer was working alone with a high workload, but this did not deter the radiographer from providing the extra support and care that the patient required.
- Chaperone signs were displayed across outpatient and diagnostic imaging waiting areas. Staff were observed asking patients if they required a chaperone during consultations.
- Staff knocked on doors and waited for a response before entering.

Understanding and involvement of patients and those close to them

- All the patients we spoke to felt well informed and involved in the decision making regarding their care and treatment from start to finish.
- We observed staff explaining issues to patients and families in a way they could understand. Staff employed different techniques to ensure effective communication. Staff recognised when patients required extra support to be able to become involved in their treatment plans.
- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to in the reception area and maintained eye contact when conversing.

Emotional support

- Staff demonstrated a real understanding of supporting patients who were distressed or in physical discomfort and took time to provide the additional care that these patients required.
- We observed staff realising and taking action for patients who were in distress or who were anxious, before they had voiced or demonstrated this concern.
- There were quiet rooms available for staff to take patients who had been given bad news and the trust chaplaincy service was available to support patients if required.

Are outpatient and diagnostic imaging services responsive?

Good

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

We rated responsive as good

There were only examples of service planning to meet people's needs, for example, one stop clinics. The breast

unit offered a one stop clinics where patients could see a clinician, have a biopsy and see a radiologist if required. Patients were informed if a cancer diagnosis was suspected and quiet rooms were available for patients receiving bad news. The breast unit had increased the number of clinics available to meet an increase in demand. Service plans for diagnostic imaging had not been implemented.

'Did not attend' rates were lower (better) than the England average and phone calls and texts were used to remind patients of appointments. The trust was meeting national waiting times for diagnostic imaging within six week, outpatient appointments within 18 weeks and cancer waiting times for urgent referral appointments within 2 weeks and diagnosis at one month and treatment within two months. The trust cancellation rate for appointments was 11%; the England average was 7%. Many of these clinic cancellations were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments.

There was good support for patients with a learning disability or living with dementia. Patients whose first language might not be English had access to interpreters although some staff were not aware of how to access this service. At the main outpatient reception self-service touch screen booking in facilities were available. They provided patients who did not speak English with the option to book in for appointments in their own language

The majority of patients were seen within 30 minutes in clinic.

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

Service planning and delivery to meet the needs of local people

- In outpatients, each speciality managed their own clinic lists. Outpatients as a department provided the nursing staff and room capacity to meet the needs of the clinic. There were one stop gynaecology, cataract and orthopaedic clinics.
- The breast unit offered access to one stop clinics. Appointments were offered to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by consultants. Patients who attended the one stop clinics, would see a clinician, have a biopsy taken and see a radiologist if required. If a cancer diagnosis was suspected, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options. This unit provided a responsive service for patients who were anxious in relation to a potential cancer diagnosis.
- The breast unit provided data for the Somerset Cancer Registry database which was linked to the two week wait clinic audit. As a result of evidence gained from the two week wait audits, the breast unit had changed practice to improve outcomes for patients, by providing an extra clinic to meet demand.
- The diagnostic imaging department offered a GP walk in appointment service from 9am to 4.30pm on Monday to Friday.

Access and flow

- In outpatient services, some patients used choose and book to arrange appointments, but managers could not identify what percentage of patient's used this method.
- In diagnostic imaging, electronic booking same day appointment facilities were available, which decreased the waiting times for patient's requiring more urgent review.
- 'Did not attend' rates were between 6.0 – 6.5% (January 2014 to December 2014); the England average was 7%. Phone calls and texts were used to remind patients of appointments.
- From April 2013 to February 2015, the trust achieved the referral-to-treatment (RTT) standard for incomplete pathways in every month and was above the England average between August 2013 and February 2015.
- The RTT target of 95% of patients who were waiting less than 18 weeks to start treatment that did not involve an admission (non-admitted pathway) was being met with the exception of November 2014 – December 2014.
- The national standards for cancer wait times were being met and the trust was consistently above the standard (April 2013 – December 2015). This included 93% of people whose first consultant appointment was within two weeks of a GP urgent referral; 96% of people who waited at most one month from a decision to treat to a first treatment for cancer ; and 85% of people who waited at most two months from GP urgent referral to a first treatment for cancer wait clinics.

Outpatients and diagnostic imaging

- Between January 2015 and April 2015 an average of 11% of outpatient appointments across were cancelled each month by the Trust at RHCH. The England average was 7%. The trust told us that this was primarily due to sickness, annual leave and study leave. A further 12% were cancelled by patients (the England Average was 6%). Some follow up appointments were booked up to 18 weeks in advance of the clinic date. This led to cancellations when clinical staff did not provide the six week notice period for leave requests. Evidence showed that a large proportion of these cancellations were given at short notice, with some patients being contacted on the day of the clinic to have their appointment rearranged.
- The trust aimed to offer all cancelled patients a new date at the time to avoid patients falling through the net. However, processes were being managed differently across the trust and some patients were missed. In ophthalmology and gastroenterology, for example, some patients had annual review appointments. Some patient cancellations were waiting a significantly longer time for new appointment which could be up to 18 months to two years. There were plans in place to look at improving the cancellation of outpatient clinic appointments, but these were in development and currently only focussed on the outpatient services at Basingstoke and North Hampshire Hospital.
- In diagnostic imaging, between July 2013 and February 2015, overall less than 1.5% of patients experienced diagnostic waiting times of more than six weeks. The England average overall was 2.5%.
- The waiting times for patients from arrival in the outpatient department until their consultation varied. In 2014/15, 12% of patients waited over 30 minutes to see a clinician. In all clinics, there were whiteboards displaying the current waiting times for patients. Nurses were also observed updating patients upon arrival of any expected delay.

Meeting people's individual needs

- The environment in outpatients and diagnostic imaging had adequate seating arrangements for patients to sit and wait for appointments, X-rays and scans.
- The waiting areas, consulting and imaging rooms were all wheelchair accessible.
- In clinical areas there was adequate provision to maintain a patient's privacy and dignity.
- Waiting areas were large and signage was good. However, there was no signage available for patients who did not speak English as their first language and no information leaflets were available in any other languages.
- At the main outpatient reception self-service touch screen booking in facilities were available. They provided patients who did not speak English as their first language with the option to book in for appointments in their own language.
- The trust had an interpreter service. Interpreters were available over the telephone or would attend in person to support patients during their consultations. Not all staff demonstrated having knowledge of the service or how to access it.
- Staff gave good examples of where reasonable adjustments were made for patients who were living with dementia. Dementia 'champions' had been trained and supported the outpatient team as a whole by providing advice and support when required. Nursing and radiography staff told us that if a patient was particularly distressed due to dementia, they would often be prioritised in the clinic list.
- Staff told us about services for patients who required extra support to enable them. There was a learning disability specialist nurse and of the process to contact her should a patient with a learning disability attend for a clinic appointment.
- Within the hearing aid repair clinic (part of audiology) patients were able to attend to have their hearing aids repaired. This was a walk-in service . To support patients with hearing difficulties, patients were given a pager on arrival that vibrated to alert them to go in to the clinical room for their appointment.

Learning from complaints and concerns

- Information on how to make a complaint was not displayed,
- In 2014/15, the outpatient department received three complaints. Two were about delayed or cancelled appointments and one about absent medical records. There were four complaints in diagnostic imaging. Two regarding delayed or cancelled appointments and two about treatment. These had been responded to appropriately.

Outpatients and diagnostic imaging

- Across the trust the majority of speciality outpatient complaints were for cancelled appointments and waiting times. The staff were not aware of these complaints or the learning to improve the service.
- Patient feedback was sought and welcomed across the trust. This feedback was obtained from patient surveys and comment cards. The comments were largely positive

Are outpatient and diagnostic imaging services well-led?

Requires improvement

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

We rated 'well-led' as requires improvement

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

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

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern.

Nursing staff did not identify a strong leadership presence in the outpatient department and did not feel well supported. Radiographers felt well supported by their immediate line managers. They told us that they felt well supported and valued. Staff said they enjoyed working for the trust due to the strong team support from colleagues. The CEO and Chief Nurse had a strong visible presence.

There were few examples of local innovation and improvement to services. The breast unit had fully integrated to provide a coordinated service across trust sites. In diagnostic imaging, a staff representative role was being introduced to support and implement positive changes within the department that staff members themselves had recommended.

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

Vision and strategy for this service

- There outpatient service strategy was part of a clinical services review and was currently a set of proposals. The review was planned around the delivery of a new critical treatment hospital. The review identified the need for general and locally based outpatient services which at Andover, Winchester and Basingstoke. The services would be consultant led with increased roles for advanced nurse practitioners. One Stop clinics and more complex procedures in outpatient clinics, as well as nurse led clinics were proposed as part of the discussion. Referrals could come through A&E, Assessment Unit via GP, walk-in, referral and consultants would be responsible for triage to plan appoint bookings and pathways.
- The service had short term priorities. Managers told us that improving capacity was one of their greatest concerns and the need to improve the outpatient pathway. There was an action plan, in the very early stages of development, to improve the focussed on the number of cancelled appointments. The plan was being considered for implementation at Basingstoke and North Hampshire Hospital.

- Staff were not clear about any of the specific aspects of the trust wide strategy. However, most staff told us that their main vision for the service was continually improving the patient experience and providing high quality care.
- In diagnostic imaging there was a strategy to develop services which included a comprehensive action plan. The plan included developing the skill mix of staff , for example, radiographer assistants, increasing capacity, developing education opportunities to develop and retain staff locally and integrated the diagnostic imaging service across sites so that clinical and administrative processes were aligned. This had had yet to be considered at divisional and trust board levels and interim actions were not specified.

Governance, risk management and quality measurement

- The outpatient department held monthly performance review meetings to which all senior staff were invited. Governance issues were emailed out to all the outpatient staff which included patient experience outcomes. Information on clinical risks and complaints was not shared.
- Diagnostic imaging services held monthly cross site governance meetings. During these meetings radiation protection issues were discussed. Quarterly radiation protection meetings were held and the minutes from both meetings were disseminated to all staff by email. Staff told us that they felt they were kept up-to-date in relation to governance issues.
- The senior nursing staff, from all sites, met once monthly. The focus was incident reporting and learning from incidents. Evidence was seen in relation to these meetings and copies of the minutes were generally kept in the nurses' offices.
- The outpatients and diagnostic imaging departments had their own risk registers which formed part of the family and clinical support services division risk register. Risks were identified and mitigating actions were being taken. The highest risk was identified as medical records, had been escalated to the trust risk register. Not all risks had been identified, for example, monitoring patient follow up following cancellations and radiographer's workload and delays with the radiology outsourcing service.
- Risks specific to specialities were on the speciality risk register. There had been a serious incident requiring investigation of a patient lost to follow up at an ophthalmology clinic at RHCH. The patient's sight had deteriorated in the interim. The lessons learnt from this had not been shared across the trust, for example, with staff at Andover. There had not been local actions to monitor patient's whose clinics were cancelled were appropriately followed up.
- The services did not undertake local clinical audit.

Leadership of service

- Nursing staff in outpatients told us they did not feel well supported by the leadership of their department. The staff in outpatients did not see the nurse manager lead regularly but did see the service lead.
- Radiographers felt well supported and valued by their immediate supervisors. Radiographers felt confident they could approach their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally.
- All staff felt that the CEO and the Chief Nurse provided strong, visible presence within the trust. Most staff had spoken to the CEO and found her to be approachable and accessible. Staff said that other board members were a visible entity within the trust.
- In diagnostic imaging it was considered that from senior managers to board level there was a possible 'stumbling block' that prevented local development, autonomy and budgetary responsibility. This had curtailed local level management from implementing positive changes within the department, particularly in relation to staffing which would enhance staff morale and improve services for patients. The action plan agreed at local level had yet to be considered by the division and trust board level. Interim actions were not specified.
- It was evident that outpatients and diagnostic imaging had not fully integrated across the three trust sites, each site working quite differently despite the same leadership at senior management level. The local management recognised this and in diagnostic imaging there were plans in place which were seen during inspection, to move integration forward. This was not the case in outpatients. The breast unit however, had fully integrated and provided a unified service to all patients trust wide.

Outpatients and diagnostic imaging

Culture within the service

- All of the staff we spoke to across outpatients and diagnostic imaging told us that the teams they worked in and the supportive relationships forged with their colleagues were the main reasons they enjoyed working for the trust.
- Staff demonstrated that their patients and the provision of high quality care was at the forefront of their daily practice. We observed staff supporting each other to ensure the best possible service was provided for all patients.

Public engagement

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

Staff engagement

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

Innovation, improvement and sustainability

- The breast unit had fully integrated to provide a coordinated service across trust sites.

Outstanding practice and areas for improvement

Outstanding practice

- The trust was development innovative new roles for staff, for example, majors practitioners in the emergency department and advanced critical care practitioners.
- Every medical and care of elderly ward had an activity coordinator who planned and conducted different activities for patients after consulting them. The activities included range of things such as arts and craft, music, dance, group lunches and movie time.
- Afternoon tea' session was held for patients and their relatives in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education. The session was also attended by a member of stroke association team who delivered educational sessions related to care after stroke. Patients were also given information about support available in the community.
- A nurse led eight bedded day unit in the admissions and discharge lounge for patients who required certain medical interventions. Patients were referred to this service by the medical consultants and this service was helping to meet needs of patients who required medical intervention without prolonging their stay in the hospital. Patients were highly complimentary about this service.
- When patients with complex needs on care of elderly wards were discharged to their new home, they were escorted by a member of nursing or therapy staff to who spent up to an hour with patients in their new home. This had helped in offering elderly patients with emotional support.
- The early supported discharge team helped stroke patients for up to six weeks following their discharge from the hospital. The staff felt that this gave continuity of care and supported the patients in achieving their goals following the discharge
- Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff.
- Critical care career pathways were developed to promote the development of the nursing team.
- The critical care unit had Innovative grab sheets that detailed the essential equipment to care for each patient in the event the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.
- Pregnant women were able to call Labour Line which was the first of its kind introduced in the country. This service involves midwives being based at the local ambulance operations centre. Women who called 999 could discuss their birth plan, make arrangements for their birth and ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners. Labour Line midwives were able to prioritise ambulances to women in labour if they were considered an emergency. The continuity of care and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they were also awarded second place in the Midwifery Service of the Year Award.
- The breast care unit is a fully integrated multi-disciplinary unit that was pioneering intraoperative radiotherapy for breast cancer at the Royal Hampshire County Hospital.
- The specialist palliative care team provided a comprehensive training programme for all staff involved in delivering end of life care.
- The cardiac palliative care clinic identified and supported those patients with a non-cancer diagnosis who had been recognised as requiring end of life care.
- The use of the butterfly initiative in end of life care promoted dignity and respect for the deceased and their relatives.
- There was strong clinical leadership for the end of life service with an obvious commitment to improving and sustaining care delivery for those patients at the end of their lives.
- All staff throughout the hospital were dedicated to providing compassionate end of life care.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

The hospital must ensure

- Patients in the ED are admitted, transferred or discharged within national target times of four hours.
- There is an appropriate system to identify patients with a learning disability.
- Resuscitation equipment is appropriately checked and items are sealed or tagged
- Medicines are appropriately managed and stored in surgery
- The early warning score is used consistently in surgery.
- Venous thromboembolism assessment occurs on admission for surgical patients
- Staffing in radiology complies with guidance so that staff do not have heavy workloads and manual handling risks and staff have access to appropriate advice.
- There is effective partnership working so that children and young people with mental health needs (CAMHS) have timely assessment and care reviews.
- Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.
- The outsourced diagnostic imaging service is appropriately monitored and managed to reduce delays.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.

Action the hospital SHOULD take to improve

The hospital should ensure :

- There is a name lead nurse for children in the ED as per Royal College of Paediatric and Child Health guidelines (2012)
- Staff receive appropriate training and there is a formal process in place for staff to follow to meet requirements of the Duty of Candour.
- Staff maintain infection control procedures - peripheral cannula care and catheter care and hand hygiene - at all times.
- Nurse staffing levels comply with safer staffing levels guidance.
- Medicines are appropriately managed and stored in maternity and gynaecology
- Continued action to significantly reduce the incidence of pressure ulcer and falls.
- Equipment in the Maternity unit and outpatients is appropriately checked.
- The level of staff undertaking safeguarding adults and child training needs to meet trust targets.
- The trust target of 80% for mandatory training is met.
- The availability of medical notes for outpatient clinics continues to improve and this should be audited.
- There is a formal method to identify patient's whose condition might deteriorate in the outpatient clinic.
- Clinical audit programmes continue to develop.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Controlled drugs in liquid form are managed and stored appropriately in all the medical wards
- All staff have a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and mental capacity assessments are always documented or regularly reviewed in patient care records.
- There is guidance around the frequency and timeliness of bed moves so that patients are not moved late at night and several times.
- Review single sex bay arrangements on Victoria Ward to ensure patients privacy and dignity is not compromised.
- Review the need for developing a Critical Care outreach service.
- There is a critical care rehabilitation pathway.
- Paediatric critical care guidelines are reviewed and updated.
- There is a clear process and assurances for critical care staff who have been redeployed elsewhere in the hospital to return to the unit when a patient is admitted to the critical care unit.
- Information for patients is available in accessible formats.
- All DNACPR order forms are consistently completed accurately and in line with trust policy.

Outstanding practice and areas for improvement

- Review the process for 'fast-track' discharge to meet the standards for 90% standard to be discharged with the right level of care within 48 hours if there preferred place of death is home.
- Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed in Maternity and gynaecology.
- There is access to seven day week physiotherapy for children and young people with cystic fibrosis.
- Complaints are responded to within the trust target of 25 days and there are formal methods to feedback complaints to staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment Regulation 12 (1) (2) (a), (b), (c), (e), (g), How the regulation was not being met: The trust must ensure: · Resuscitation equipment is appropriately checked and items are sealed or tagged · Medicines are appropriately managed and stored in surgery · The early warning score is used consistently in surgery. · Venous thromboembolism assessment occurs on admission for surgical patients · Staffing in radiology comply with guidance so that staff do not have heavy workloads and manual handling risks and staff have access to appropriate advice. · The outsourced diagnostic imaging service is appropriately monitored and managed to reduce delays. · There is effective partnership working so that children and young people with mental health needs (CAMHS) have timely assessment and care reviews. · Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance Regulation 17 (1), (2) (a), (b). How the regulation was not being met: The trust must ensure: · Patients in the ED are admitted, transferred or discharged within national target times of four hours. · There is an appropriate system to identify patients with a learning disability. · There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up