Hampshire Hospitals NHS Foundation Trust

Basingstoke and North Hampshire Hospital

Quality Report

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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	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

Basingstoke and North Hampshire Hospital (BNHH) is one of the acute district hospitals, and is based just outside Basingstoke in North Hampshire. Services provided at BNHH include urgent and emergency care, medical care, surgery, critical care, maternity and gynaecological services, children and young person's services, end of life care, and outpatient and diagnostic services.

The hospital also provides some specialist services including services for rare or complex illnesses for patients across the UK, including liver cancer, colorectal cancer and pseudomyxoma peritonei (a rare lower abdominal cancer). The purpose built diagnosis and treatment centre (DTC) opened in 2005. The regional haemophilia service is based at BNHH, and they have links with University Hospital Southampton NHS Foundation Trust, Frimley Park Hospital NHS Foundation Trust, Royal Surrey County Hospital NHS Foundation Trust and Royal Brompton and Harefield NHS Foundation Trust for some specialised services.

BNHH has about 529 beds, and had 57,008 emergency attendances from April 2014-March 2015, and over 297,507 outpatient attendances from May 2014-April 2015.

There are 5124 staff employed by the trust, working across the hospital sites. BNHH site employs approximately 827 WTE 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 is a Foundation Trust, and is deemed as low risk according to our Intelligent Monitoring system (Band 6).

The inspection of BNHH took place on 28 - 31 July, with additional unannounced inspection visits on 13 and 14 August 2015. The full inspection team included CQC senior managers, county managers, inspectors and analysts. Doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers also joined this team.

We rated BNHH as overall good. We rated it as 'outstanding' for providing caring services, and good for effective, responsive, well-led care. We rated it as 'requires improvement' for safety.

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, although this was not consistent and in surgery one ward needed to improve its practices.

Summary of findings

- Medicines were appropriately managed and stored. However, fridge temperatures were not being regularly checked and monitored on the surgical wards.
- 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 on some medical and surgical wards, specifically for resuscitation equipment.
- Overall, staff had a good understanding of safeguarding adults and children.
- 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 emergency medicine, medical and older people's care and surgery. 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 for example, by developing skills in health care assistants and having ongoing recruitment campaigns, including employing staff from overseas. However, we found in some areas, patient needs were not being met.
- Midwifery staffing levels did not meet national recommendations but staff worked flexibly and could provide one to one care for all women in labour.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting system. Senior staff we spoke with were aware of duty of candour and talked about the importance of being open and transparent with patients and their families.

Are services effective?

- Staff were providing care and treatment to patients based on national and best practice guidelines. In some areas guidelines had been unified across the trust for consistency of care.
- 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, for example, for stroke rehabilitation.

Summary of findings

- Patients with chest pain were taken to Basingstoke and North Hampshire Hospital as the designated centre for specialist treatment if possible. The hospital's performance was better than national average for patients with non-ST segment elevation myocardial infarction (a type of heart attack) who were seen by a cardiologist or a member of the team and treated on a cardiac ward or unit. The hospital performed below the national average for patients being referred for or had angiography.
- 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 at the weekends and this was 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 and housekeeping staff 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 the AAU and the eye day care unit 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
- 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?

Summary of findings

- 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, the acute assessment unit. There was also joint work with partners, for example, to in-reach services for psychiatric assessment. Other areas were working on how to increase capacity.
- Bed occupancy in the hospital was below the England average of 88% although it 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) information demonstrates that these patients were regularly assessed. There was only one patient outlier during the inspection.
- 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 trust was achieving the 18-week referral-to-treatment time target for medical patients and some surgical patients. 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 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 10%; 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 to 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 trust had problems with increasing numbers of delayed transfers 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.

Summary of findings

- 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 to further improve processes to manage risk and quality.
- Many 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 across Basingstoke and North Hampshire Hospital and Royal Hampshire County Hospital and Andover War Memorial 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 the use of social media in maternity 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, advanced critical care practitioners.

We saw many areas of outstanding practice including:

- The trust is one of only two designated specialist treatment centres in the country for treatment of Pseudomyxoma. This is a very rare type of cancer that usually begins in the appendix, or in other parts of the bowel, the ovary or bladder. The hospital has treated more than 1000 such cases. The diverse multidisciplinary team has developed the skills to help patients through this extensive treatment, and share their knowledge on international courses and conferences.
- Through audit, surgeons working at the trust have changed practice world-wide, such as new techniques for the biopsy on operable tumours and the benefits of waiting six weeks after completing chemotherapy before performing liver resection.

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 a range of things such as arts and craft, music, dance, group lunches and movie time.
- GP's had access to electronic information held by the trust. This meant they were able to access electronic discharge summaries with up to date information available about care and treatment patients had received in hospital.
- A LEGO brick Model, designed by a play leader, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension. The model had been adopted for use in other hospitals.
- 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 identifying patients with a learning disability.
- Nurse staffing levels comply with safer staffing levels guidance.
- Resuscitation equipment is appropriately checked, sealed and tagged.
- Medicines are appropriately managed and stored in surgery.
- Controlled drugs in liquid form are managed and stored appropriately in all the medical wards.
- The early warning score is used consistently in surgery and a system is developed for use in outpatients.
- Venous thromb-oembolism assessment occurs on admission for surgical patients.
- Resuscitation equipment is appropriately checked and items are sealed and tagged.

In addition the trust **should** ensure:

- Uncontrolled access to, and observation of, the resuscitation room from short stay is prevented.
- X-ray warning lights for the resuscitation room work appropriately.

Summary of findings

- 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.
- The separate children's area in the ED is visible in the main department, and access in the main waiting room is restricted.
- Staff using the relative's room in the ED have appropriate security, such as a viewing window in the door and/or panic alarm.
- Staff maintain infection control procedures at all times.
- Medicines are appropriately managed and stored in maternity and gynaecology.
- Staff use and appropriately sign up to date approved Patient Group Directions (PGDs) in the eye unit in the ED.
- Continued action to significantly reduce the incidence of pressure ulcer and falls.
- Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed in Maternity and gynaecology.
- An early warning score system is developed for use in outpatients.
- Equipment in the Maternity unit is checked and documented as per trust policy.
- 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.
- Records on the gynaecology ward are stored securely to prevent unauthorised access.
- The availability of medical notes for outpatient clinics continues to improve and this should be audited.
- National guidelines are followed when administering intravascular contrast in the Candover Unit.
- Staffing is improved in radiology to decrease high workloads.
- Staff in maternity have appropriate training to complete the new assessment booklet.
- There are arrangements in place to support lone working in the mortuary.
- Clinical audit programmes continue to develop.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Children's discharge summaries are completed within 48 hours.
- Review the Critical Care outreach service at night.
- 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 AAU and facilities in the eye day care unit to ensure patients privacy and dignity is not compromised.
- 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.
- Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.
- 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.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Complaints are responded to within the trust target of 25 days.

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 service was rated as 'requires improvement' for responsive services. The department had a culture of safety, and incidents were reported and actions were taken in response. The department was visibly clean. The management of some medicines needed to improve. Patients gave us positive feedback about the care they received, and the attitude of staff. Patients were treated with dignity, respect and compassion. Patients and their relatives told us they felt involved in decision-making about their care. The service needed to improve its' responsiveness. The hospital was not always meeting the national emergency access target for 95% of patients to be admitted, transferred or discharged from A&E within four hours, and this was mainly down to a wait for a bed elsewhere in the hospital. However, the department met this standard in five months of 2014. Patients were, however, initially assessed very quickly, and treated within standard times. There was good support for patients with mental health conditions and patients living with dementia, but staff required more training to provide a high level of appropriate support to patients with a learning disability. The numbers of staff attending safeguarding training needed to increase. Staff also required a greater understanding of deprivation of liberty safeguards (DoLS). The emergency department was well-led by the senior nurses and doctors. The departmental strategy and vision was understood by staff. The culture within the department was one of strong, open leadership, mutual trust and respect.
Medical care	Good 	We found that medical care (including older people's care) was 'good' for effective ,caring, responsive and well led and 'required improvement' to be safe. Process and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents. Themes from incidents were discussed

Summary of findings

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.

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.

However, most medicines were managed appropriately for safe use. However, the controlled drugs on the Acute Assessment Unit (AAU) were out of date. Infection control procedures were not always followed on all wards, and resuscitation equipment was not appropriately checked, stored and up to date on all wards.

There was a significant shortage of nursing staff on the medical and care of elderly wards. The trust was trying to use bank nurses where shortages were identified. However, we found that safer staffing levels at night were not always met on F1,F3 and E2 wards. Staff on the wards told us this was a risk to patients because these wards had elderly patients with higher risks of falls and patients living with dementia. Medical staffing, across the medical services, was appropriate and covered medical outliers well.

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 diabetes care and patients who may of had a heart attack. Where outcomes were worse than the England average, for example, for stroke rehabilitation, there was an action plan to address areas for improvement.

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.

Summary of findings

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 was one medical outlier 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 groups.

Summary of findings

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. Some patients did not have their medication at the required time. There were not always adequate numbers of nursing staff to meet the assessed needs of patients.

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 95 - 99%. The early warning score was not consistently being used to identify patients whose condition might deteriorate. 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 from therapists 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 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.
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. 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.
There were effective risk management processes in place with processes to ensure learning from incidents was shared across the critical care units at both BNHH and RHCH.
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 units at BNHH. There was a culture of mutual support and respect, with staff willing to help the unit at RHCH 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. There had been one Never event (a serious, largely preventable patient safety incident which should not occur if the available preventative measures had been implemented) in the maternity service in May 2015.
We saw information to support the reason for the never event had been comprehensively investigated and systems were in place to minimise the risk of recurrence.

Summary of findings

Midwives completed comprehensive risk assessment processes from the initial booking appointment through to post-natal care. Identified risks were recorded and acted upon across the service.
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 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 RCOG, Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust to ensure all services worked to the same guidelines.
Women had access to a variety of methods for pain relief throughout the service. 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 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 consistently gave us positive feedback about the care and treatment they had received. We observed they were treated with dignity and respect and were

included in decision making about their care. Women were able to make choices about where they would like to deliver their babies. Women and their families, had access to sufficient emotional support when required. The gynaecological service met the referral to treatment time target 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 a clear strategy and vision for the service which was focussed towards the development of a new hospital. Staff and the members of the community had been consulted about the changes to service provision and had been involved in the architectural design of the new building. Short term strategies had been developed to ensure staff were ready for the move and guidelines were embedded across the sites. However, there had not been short and medium term plans for 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 ensure it was 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 always 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 October 2013 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 at the weekends.

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, and 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 links 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.
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, a holistic patient-centred approach was evident.
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 excellent 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 and the low staffing levels in the mortuary.

Summary of findings

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.
Staff treated people with compassion, kindness, dignity and respect and feedback from patients and their families were consistently positive.
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. There was an identified shortage of side rooms for those patients identified as being in the last hours of life.

Outpatients and diagnostic imaging

Good

The outpatient and diagnostics imaging services were 'good'for safe, responsive services, and well-led services. It was 'outstanding' for the delivery of a caring service.
Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the care quality commission.
The environments were visibly clean and staff followed infection control procedures. Equipment was well maintained and medicines were appropriately managed and stored. Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used. Patients were assessed and observations were performed, where appropriate. However, there was not a tool in use to identify patient's whose condition might deteriorate in outpatients. Interventional radiology there was evidence of the WHO checklist being completed and patient protocols in place. However, in the Candover Unit national guidelines for interventional radiology were not always followed regarding the availability of specific staff to be available in an emergency.

Summary of findings

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

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

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

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

There was some evidence of service planning to meet people's needs. For example, the breast unit offered access to one stop clinics where patients could see a clinician, have a biopsy and see a radiologist if required.

National waiting times were met for outpatient appointments, cancer referrals and treatment and diagnostic imaging. However, the trust had a higher number of cancelled clinics, many of which were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not reviewed to ensure the timeliness of re-appointments for their condition.

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

Summary of findings

led and complex procedure clinics for outpatient services. Staff were not aware of how the strategy would develop in their departments. The hospital had plans to address issues regarding 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 required further development in the outpatient department to monitor risks and quality although these were well developed in diagnostic imaging.

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Nurses and radiographers spoke highly of their immediate line managers and told us they worked in strong, supportive teams which they valued.

There were some 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 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.

Basingstoke and North Hampshire Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Basingstoke and North Hampshire Hospital

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.

Basingstoke and North Hampshire Hospital (BNHH) is one of the acute district hospitals, and is based just outside Basingstoke in North Hampshire. Services provided at BNHH include urgent and emergency care, medical care, surgery, critical care, maternity and gynaecological services, children and young person's services, end of life care, and outpatient and diagnostic services.

The hospital also provides some specialist services including services for rare or complex illnesses for patients across the UK, including liver cancer, colorectal cancer and pseudomyxoma peritonei (a rare lower abdominal cancer). The purpose built diagnosis and treatment centre (DTC) opened in 2005. The regional haemophilia service is based at BNHH, and they have links with University Hospital Southampton NHS Foundation Trust, Frimley Park Hospital NHS Foundation Trust, Royal Surrey County Hospital NHS Foundation Trust and Royal Brompton and Harefield NHS Foundation Trust for some specialised services.

BNHH has about 529 beds, and had 57,008 emergency attendances from April 2014-March 2015, and over 297,507 outpatient attendances from May 2014-April 2015.

There are 5124 staff employed by the trust, working across the hospital sites. BNHH site employs approximately 827 WTE 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 is a Foundation Trust, and is deemed as low risk according to our Intelligent Monitoring system (Band 6).

The inspection of BNHH took place on 30 and 31 July, with additional unannounced inspection visits on 13 and 14 August 2015. The full inspection team included CQC senior managers, county managers, inspectors and analysts. Doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers also joined this team.

We rated BNHH as overall good. We rated it as 'outstanding' for providing caring services, and good for effective, responsive, well-led care. We rated it as 'requires improvement' for safety.

Detailed findings

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 BNHH on 31 July 2015. We completed the inspection through unannounced and out-of-hours inspections to services on 13 and 14 August 2015.

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

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

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

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

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

Facts and data about Basingstoke and North Hampshire Hospital

Basingstoke and North Hampshire Hospital: **key facts and figures**

Basingstoke and North Hampshire Hospital (BNHH) is the acute district general hospital provided by Hampshire Hospitals NHS Foundation Trust, outside the town of Basingstoke.

Detailed findings

1. Context: BNHH

- Context: BNHH has around 529 beds providing the following leading specialties: Medical Oncology; General Surgery; Urology; Critical Care Medicine; Trauma & Orthopaedics; Ophthalmology; Accident & Emergency; General Medicine; Cardiology; Gastroenterology; Endocrinology; Respiratory Medicine; Geriatric Medicine; Rehabilitation; Local Specialist Rehabilitation Services; Paediatrics; Community Paediatrics; Obstetrics; Gynaecology.
- 57,008 A&E attendances (April 2015 - March 2015)
- 297,507 outpatient appointments (May 2014 – April 2015)
- The number of staff, approx. 827 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 BNHH.
- 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.

Detailed findings

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 BNHH). 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 93.2% (BNHH) - 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 - BNHH:

There have been five inspections at BNHH since 2011. 13 outcomes were inspected, and the hospital was compliant with 12 of these.The non-compliant Outcome 9 (Medicines management) was in November 2013. The only inspection since then is the comprehensive inspection referred to in this report.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	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	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	☆ Outstanding	Good	Good	Good
Overall	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Notes

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 Basingstoke and North Hampshire Hospital (BNNH) serves the towns of Basingstoke, Alton, Andover and surrounding villages. It provides a service 24 hours a day, seven days a week to both adults and children. It does not provide major trauma as there is a major trauma centre at Southampton General Hospital. The ED is the designated receiving unit for patients with chest pain; the hospital offers specialist care for these patients.

The adult emergency departments of Hampshire Hospitals NHS Foundation Trust last year saw 116,280 patients. This figure includes 20% of patients who are under the age of 16 years attending the Royal Hampshire County Hospital ED. Of these patients 21, 926 were admitted to hospital. Within the department there was a short stay unit for where patients could be monitored overnight if required.

During our inspection of this ED we spoke to 12 patients and 18 members of staff, we also reviewed 5 sets of patient 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.

Summary of findings

The emergency department was good at providing safe, effective, caring and well-led services but required improvement to provide responsive services.

The department had a culture of safety, incidents were reported, learning from these was shared and changes made as a result. The department was visibly clean and hygienic. Medicines were appropriately managed and stored. Staff adhered to infection 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 high number of nursing vacancies within the department so agency staff were used. Staff worked flexibly to provide appropriate skill mix and staffing levels, and recruitment was ongoing.

Safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place.

The department provided effective care that followed national guidance and was delivered to a high standard. Pain relief was offered and the effectiveness of the treatment 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 were treated with compassion, dignity and respect.

Urgent and emergency services

The service had some improvement to make in terms of its responsiveness. The hospital was not always meeting the national emergency access target for 95% of patients to be transferred to a ward or discharged from an ED within four hours. Patients were however, assessed and treated within standard times. There was good support for patients with a mental health condition and patients living with dementia.

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

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 Basingstoke and North Hampshire Hospital and Royal Hampshire County 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 regularly checked to ensure it was safe to use.

The requirements for Safeguarding children, young people and vulnerable adults were understood by staff although staff participation in child protection training was lower than the trust 80% target.

There were effective procedures to assess and stream patients in the department. 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, and provide care and observation for them. The department had appropriate medical staffing levels, with consultants present 16 hours a day.

There was a high level of nursing vacancies. Although there were no children's registered nurses employed, there were satisfactory arrangements with a named link nurse. However, the Royal College of Paediatrics and Child Health guidance (2012) suggests that there is a named lead nurse for children within an ED. There was a consultant lead for children with specialist training. Infection control procedures across the department were being followed and action was being taken on specific areas to improve compliance with standards.

Incidents

- Incidents and accidents were reported using a trust wide electronic system, all staff had access to this and understood the incidents that required reporting.

- Medical, nursing and support staff were aware of their responsibilities in reporting incidents and we saw examples that had been submitted across the department. Staff were aware of the benefits of reporting "near misses" and told us that they did this.
- There were various systems to ensure that the learning from incidents was shared across the departments. There were governance meetings that shared learning from incidents; there was also a monthly newsletter, written by the medical team that was shared across the departments. The department also used 'Top 10 Tips' which was a digest of learning from incidents, these were discussed at handover rounds.
- Some staff were aware of the requirements of the Duty of Candour, but this knowledge was not consistent across the department.
- Mortality and morbidity meetings were attended by doctors and nurses to ensure that any learning was shared.
- The consultants split their time equally across Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital departments. This helped ensure that learning from incidents was communicated and changes to practice implemented across both departments.

Cleanliness, infection control and hygiene

- The emergency department (ED) was visibly clean. There were hand sanitising gels in use at the main doors to the department. We observed these were being used by people entering the department. There were sufficient facilities for hand washing.
- 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 80% compliance with the standard. It was identified that staff did not always wash their hand when touching patient surroundings.
- All Staff we observed 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 equipment were also carried out such as checks on commodes.
- Patients with a cannula (a tube into a vein to allow fluid or medicines to be administered) were 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 being implemented to increase compliance with the standard.
- Audits were also carried out for patients with a urinary catheter (or who had one inserted while in the department) to ensure correct documentation was completed. This was aimed at reducing patient infections from urinary catheters.
- There were no reported incidences of MRSA or Clostridium difficile in the department. Patients admitted with a suspected gastrointestinal infection would be kept isolated from other patients and infection control precautions were taken. Audits showed that care plans were not always completed and action was being taken.
- There was appropriate waste management processes in place to ensure 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.
- Chemicals required for cleaning a blood spill (or other body fluid) were also stored appropriately.
- Fabric curtains were in use around cubicles, we found no schedule for the changing them. Curtains were changed at the request of staff when they became visibly soiled.

Environment and equipment

- There were four assessment and treatment rooms which were used by emergency nurse practitioners (ENPs) for seeing and treating patients with minor injuries. One room was used exclusively for triage.
- There was a receptionist located at the desk, who had a good view of the waiting room. A receptionist was on duty 24 hours a day. The desk itself did not have an area that was accessible to a wheelchair user. This meant that it did not comply with disabled access legislation. The CCTV for the department (internal and external) had monitors at this desk; they were also connected to hospital security. There was a 'panic button' at the reception desk.
- Children attending the department had to wait in the main waiting room prior to triage, after which they would use the separate children's waiting area. This was sometimes inappropriate if the waiting room was crowded or other attenders where rowdy.

- The waiting room designed for children had an adjoining treatment room. There was uncontrolled access to this area from the main waiting room, and these rooms were not covered by the CCTV.
- The minor injury area consisted of five cubicles and side room (this was used for children).
- The majors' area had five trolleys with a side room which could be used for isolating a patient with a suspected infection.
- The resuscitation room was equipped with four bays, with one bay equipped for children and babies. Resuscitation equipment was checked daily to a checklist. This was signed as checked by staff every day.
- 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. This room was at the centre of the department and was also used to interview patients with mental health problems. When used for this purpose, the room did not have an additional escape route or an assistance alarm.
- The department was tidy and fit for purpose, with equipment maintained in good order. On the day of inspection, the emergency alarm had failed and was being replaced.
- Access to x-ray and the CT scanner was a distance from the department, but painted arrows helped patients to navigate the route.
- The short stay ward had seven beds, two of which were side rooms. These side rooms could be used for end of life care or isolation care if required. The toilets in the short stay ward had access restrictions due to the storage of equipment.
- There was uncontrolled access through a door to the resuscitation room from the patient toilet in the short stay ward. It would be possible for a patient to walk through into the resuscitation room, or watch activities through the window in the door. The resuscitation room also had ceiling mounted X-ray. There were lights outside the resuscitation room to prevent unauthorised entry. However, these lights were not working in caution mode (Amber) to warn about the X-ray. This meant there was a possibility that patients could walk into the main resuscitation room, from the patient toilet in the short stay ward, and be exposed to x-rays as well as interrupting a patient resuscitation.
- The relatives' room had no escape route or assistance alarm and was used for the assessment of patients with mental health problems.
- Patients who were brought into the department by ambulance sometimes had to wait on trolleys. When this occurred the hospital ambulance liaison officers (HALOs) provided initial assessment, observation and care for these patients.

Medicines

- The storage of medicines in the department was appropriate with locked cupboards and refrigerators. However, we found some three stored medicines to be out of date. These medicines would all be required urgently. The stock control system for medicines was not effective. This was brought to the attention of staff during the inspection who arranged for them to be replaced.
- The storage of controlled drugs (CDs) was appropriate. These were checked regularly and reconciled against stock levels. Medicines used in emergencies were checked daily, such as those in the resuscitation room, there were no out-of-date medications found.
- Medicines that were used to transfer critically ill patients around the hospital were stored correctly.
- There were local microbiology protocols for the administration of antibiotics that were being used by prescribers.
- Refrigerators for temperature controlled storage of medicines were kept locked and the temperatures were checked, although this was not always done daily as specified on the check sheet.
- The department used patient group directions (to allow some drugs 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 were then scanned on to computer to allow good access to records for patients who have previously attended the department. Paper records were disposed of using a secure shredding service that ensured 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 national early warning system (NEWS). Records for children included consideration of safeguarding checks. The Paediatric Early Warning System (PEWS) was used for children.

- Records also included risk assessments for pressure ulcers, falls and infection control. Nursing staff also completed a checklist to assist them to identify patients who are vulnerable or at risk of mental health problems. This included if the patient was the carer of a vulnerable person.
- Patients in the Majors area had their NEWS scores displayed on a whiteboard and included details of when there 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. 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 73% of nursing staff, this was below the trust target of 80%. 53% 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 73% of nursing and 53% of medical staff.
- Staff had access to information and a pathway 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 80% target. The Infection control training was attended by 13% of doctors and by 48% of nurses; manual handling training by 33% of doctors and 67% of nurses; Information governance (IG) by 88% of doctors and 49% of nurses (the trust target for IG training was 95%).
- The trust data on mandatory training showed that attendance on other modules, such as conflict resolution, health and safety and fire was less than the 80% target.

Assessing and responding to patient risk

- 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 equipped for the resuscitation of adults, children and babies. The ambulance service would phone ahead to allow the department to prepare to receive such a patient if the situation allowed.
- 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 a specialist centre for the treatment of stroke. Patients with chest pain would be taken to Basingstoke and North Hampshire Hospital for specialist treatment. 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 NEWS to ensure that deterioration is detected and escalated appropriately, for children the paediatric early warning system (PEWS) was used.
- In the event of a critically ill child attending the department, there were processes in place for quick referral of the child to a paediatrician. There was a protocol in place that very ill children requiring time critical transfer to another specialist facility would be collected directly from the hospital by the Southampton and Oxford retrieval team (SORT). The SORT team would provide specialist staff to support and treat the child during the transfer.

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.

- The ED at Basingstoke and North Hampshire Hospital had a 30% nurse vacancy rate and was unable to cover a shortfall with its own nurses. Staffing rotas in June and July 2015, demonstrated that the department escalated issues quickly and met planned staffing levels by using agency staff and staff from other departments when required.
- The NEWS score was used as a measure of a patient's acuity, and to identify the most appropriate area in the department to care for them.
- Handovers were conducted by the doctor and nurse in charge of the department. In addition there were departmental consultant led reviews attended by the nurse in charge, junior doctors, emergency nurse practitioners (ENPs) and majors' practitioners (MAPS). There was no specific handover tool used, this was identified as a risk and appeared on the departments risk register.
- The department also employed a trauma nurse coordinator who attended trauma calls. This post provided education and training as well as a link with the major trauma centre at Southampton General Hospital.
- The unit had an appropriate number of ENPs as well as advanced nurse practitioners who were managed and supervised separately from the department's own nursing staff. These staff led the treatment of patients with minor injuries.
- The department also had four trainee MAPs to support with critically ill patients in the majors area. These staff also coordinated the major incident training for the department.
- General assistants were responsible for topping up supplies, but could also carry out some clinical duties and move patients around the department. They were very accessible and responsive via a two-way radio and bleep system.

Medical staffing

- 17 Consultants worked across both sites of the trust; Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital EDs. Both sites were described by consultants as being friendly and a good place to work. The consultant rota was divided into two shifts covering 8am-6pm and 1pm-9pm. The consultants we spoke to told us they spent between 8-10 hours in the department at weekends. Consultant cover in the department was provided for 16 hours per day. This is compliant with the College of Emergency Medicine (CEM) recommendations.
- Middle grade doctors were in the department 24 hours per day, over a variety of shifts. 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 with told us that they were sometimes not able to access education and training due to departmental commitments. Training sessions provided did not entirely meet the learning needs of middle grade doctors.
- The doctor in charge on any shift wore a distinctive red arm band to indicate who they were, for staff and patients.
- Departmental consultant led board rounds that occurred at 8am, 1pm and 5pm daily, and were attended by the nurse in charge, junior doctors and MAPs. The purpose of these handovers was to ensure everyone had an overview of how the department was running.
- One consultant had been appointed as the lead for children across Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital as they had specialist training.
- Junior doctors we spoke to told us that the department was an excellent experience and they would recommend it to colleagues. High quality departmental teaching occurred regularly and there were good educational opportunities. Junior doctors told us that

the consultants were supportive and would attend the department if needed. There were sufficient staff in the junior doctors' rota to mean that gaps in staffing could be covered without the use of locums.

Major incident awareness and training

- There was a major incident plan for the ED. Staff were given regular training on how this plan would be implemented, this was facilitated by the majors practitioners. The plan, updated in May 2013, was divided into 'action cards' which were clear and concise.
- Materials and supplies for dealing with hazardous materials that may be required in the event of an incident were available in a designated storeroom in the department.
- Security for the department was good, staff used electronic pass cards to gain access to the clinical areas. There was CCTV in use 24 hours a day and this was continually recorded. There was access to security, which also had sight of the department's CCTV.

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 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 specialist training for the speciality. Multidisciplinary working was evident ensuring the patient was at the centre of their care.

Staff had a good understanding of the Mental Capacity Act, but were less familiar with Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- Policies based on National Institute for Health and Clinical Excellence (NICE) and College of Emergency Medicine (CEM) guidelines were in use in the department, some were accessed via the trust intranet. Posters were displayed in discreet clinical areas to highlight changes to clinical guidance to raise awareness. There was a change memo file to communicate any procedural changes to all staff.
- A range of clinical care pathways was used that aligned with national guidelines.
- The service met the requirements set out in the 'Standards for children and young people in emergency care settings' document.
- Medical and Nursing care was provided in line with 'Clinical Standards for Emergency Departments' guidelines.
- The hospital was the designated receiving unit for patients with chest pain, as the hospital could provide specialist treatment for patients with myocardial infarction (heart attack).
- 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.
- There was a working clinical audit programme and evidence of learning and improvement as a result. Information was shared across the trust sites. An audit of renal colic demonstrated improvements in the assessment of patients and reduction in hospital admissions.

Pain relief

- Pain scores were used as part of the normal observations to record patients' pain and to ensure that medicines given for pain were effective. Pain scoring tools specifically designed for children were also in use, this was recorded in the patient record.
- Nursing records demonstrated that patient's pain was assessed and recorded at triage, and this was reassessed regularly.

- Patient Group directions were in use to allow nursing staff to administer some agreed medicines such as pain relief without a prescription. These were easily located in the department and up-to-date for nursing staff to access.
- The A&E survey data about pain relief for the trust puts the department as in line other trusts' in England.

Nutrition and hydration

- Patients who were assessed as able to eat and drink were offered food and drinks. Relatives attending with critically ill patients were also offered refreshments.
- Food could be provided for patient's out-of-hours if required.
- There was a vending machine for snacks located in the waiting area, and water was available.

Patient outcomes

- The patient information system ensured that all patients with certain serious conditions were seen by a consultant prior to being discharged from ED.
- 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. 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. Five of the 12 CEM standards were met in the 2013-14 audit for severe sepsis and septic shock. The sepsis pathway had been put on display in the department, and the majors practitioners were taking a lead in improving compliance towards the CEM standards. The current audit data for the ED reported compliance with the standard as in the lower quartile for England. However, the data was based on only two patients.
- The unplanned re-attendance rate did not meet the national standard in the period between April 2013 and January 2015. However the performance was better than the average across England over this period.

Competent staff

- The trust data on appraisal rates showed that less than 50% of nursing staff below band 7 had an appraisal last year. Appraisal rates for medical staff were higher for senior doctors (75%) and below 56% for junior doctors.
- The department did not have an educational facilitator in place, the funding to recruit one was being discussed.
- Trust data demonstrated that the ED staff had not met the 80% participation rate in infection control or safeguarding adults and children.
- 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 staff's 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 at the trust, reports that the adequacy of induction processes was in the lower quartile of results.
- Study sessions were advertised for clinical learning, and staff were kept up-to-date with a newsletter that they found useful. Although this was produced by the medical team all staff contributed to the content.

Multidisciplinary working

- Staff reported good working relationships with specialist teams who were called to review patients in the department.
- The emergency department had access to a therapy service to facilitate discharge for patients with complex needs. Staff told us that this service was effective in getting patients with complex needs home.
- 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.
- Alcohol and substance misuse liaison team were based at the hospital and relationships were established with the team in ED.
- Access to mental health assessment was through Southern Health NHS Foundation Trust who provided staff from an adjacent hospital on the campus. This service was very responsive and was provided by three named mental health practitioners who provided a service to ED from 8am to 9pm during weekdays. A telephone service was available for mental advice outside of these hours.
- Children and adolescent mental health patients were risk assessed before admission to the paediatric wards.

Urgent and emergency services

Seven-day services

- The department was in operation seven days a week, 24 hours per day. Consultant cover was available throughout.
- There was a GP out of hours' service provided by 'Hantsdoc' which was located within the department. Some patients attending the emergency department were seen by this service if they attended with a minor illness.
- Emergency nurse practitioners provided a nurse led treatment service between 7.30am and 12pm every day.
- There was access to diagnostic tests within the department, as well as x-rays and CT scans across 24 hours.
- Reporting on x-rays and scans was done out of normal hours by an external provider. A senior doctor told us that this service had reduced delays in diagnosis overall. However, there had been some feedback about delays in getting x-ray and CT scan reports back.

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 meant that there was immediate access to all records for any patients who were re-attending the ED.
- Access to patient records was controlled by passwords, all data was backed up safely.
- Any operational changes to the department were communicated by a 'change memo' file that was accessible to all staff and reviewed regularly.
- Staff had access to databases that provided information on poisonous substances.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff seeking consent from patients to carry out examination, observations and treatments.
- The ED team received assistance from Southern Health NHS Foundation Trust staff in regards to the assessment of mental capacity to consent to treatment. Senior staff acknowledged that there was insufficient training in the assessment of capacity with patients with a learning disability.
- Nursing staff had an awareness of the requirements around the Mental Capacity Act and had been trained but were less secure in their knowledge of 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 majority of 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.

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

Compassionate care

- The reception desk was open and had a good view of the large waiting room. The space from the waiting room seating ensured that it was less likely personal information would be overheard. The trust was rated as similar to other trusts' in England on the question of being overheard talking to the receptionist in the A&E survey data for 2014.

Urgent and emergency services

- We observed nurses and doctors providing care in the department. Staff demonstrated respect for the individual patient's personal, cultural and social needs. 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 during treatment or examination. Staff responded promptly to the needs of patients in the department. Relatives commented that staff were caring and maintained the patient's privacy and dignity during assessment and treatment.
- Friends and Family test results showed that between 86%-97% (results March 2014-February 2015) of patients' would recommend the department to their friends and families. The response rate to the survey was higher than the England average.
- The A&E survey results showed that the ED questions related to caring were in line with other trusts in England.

Understanding and involvement of patients and those close to them

- Most relatives and patients we spoke with were very happy with the service, as they were kept informed and assessed promptly. They were satisfied with the information and choices they were given in relation to their treatment.
- There was a relative's room adjacent the main desk area. This was used to accommodate the families of critically ill patients who were being cared for in the majors' area or resuscitation room.
- A patient brought to the department with an untreatable condition could be given end of life care in a cubicle in the short stay ward. This provided a more appropriate environment for the last hours of life and allowed family members to remain with them.

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 sometimes restricted by bed availability within the hospital. This 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 below the England average. Problems with bed availability had 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 with chest pain.

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 Basingstoke and North Hampshire. 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 chest pain. 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.
- The trust liaised with the local NHS mental health services to provide mental health assessment services, including referral to a psychiatrist. There were named mental health practitioners available on weekdays. They were based at a unit near the hospital and provided a responsive service. This link also assisted the department with patients who required 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, we were not informed of any plan to change this.
- The hospital employed two hospital ambulance liaison officers (HALO) via another provider. These were trained ambulance personnel who take handover from ambulance staff. The HALOs also provide initial assessment, observation and care for patients if they were waiting on trolleys. This allowed the ambulance to be released to be available for emergency calls. This service worked between 10.00am to 10.00pm with a cross over shift covering 12am to midnight, seven days a week.
- The GP service provided by 'Hantsdoc' was located within the department to provide access to assessment and treatment of minor illness. This was a key development in increasing the department's capacity as it was available across 24 hours.

Meeting people's individual needs

- 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 small treatment room was available within the children's waiting area.
- The main waiting room was equipped with accessible toilets; these had facilities for changing babies. There was a television in the waiting room and a free phone taxi service was available. There were vending machines for waiting people to purchase hot drinks and snacks.
- The waiting room had sufficient suitable seating for patients and relatives. It was spacious and had CCTV monitoring. There were toilets equipped with baby changing facilities. The waiting room was shared by patients who were attending the 'Hantsdoc' GP service. As a consequence of this, staff told us the waiting room became hectic at busy times.
- Children attending the department had to wait in the main waiting room prior to triage, after which they would use the separate children's waiting area. This was sometimes inappropriate if the waiting room was crowded or other attenders where rowdy.
- There was a waiting room designed for children, with an adjoining treatment room. These rooms were decorated with children in mind 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. The department also had a resource folder containing patient centred key words in many languages.
- There was not a passport system in use to help identify patients with a learning disability. Staff told us that they could access an in-reach team to provide them with advice in dealing with a patient with a learning disability. They also acknowledged that staff had not received training in this area.
- 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. Training in dementia care was offered to staff in ED.
- There was a box of resources for use with patients who were at end of life in the department.

Access and flow

- Black breaches occur when an ambulance has arrived with a patient but there is a delay of 60 minutes or more before handover the patient to ED staff. The hospital reported 100 black breaches during the period January 2014 – January 2015. A lack of bed availability in the hospital was the main reason stated 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).

- 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 met on five out of 13 months. The average over this period was 93.5%. This was also below the average for England from August 2013 to January 2015.
- 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 these meetings become more frequent.
- A consultant identified that the demand for hospital beds meant that there was pressure on the department to accept medical and surgical patients into the short stay unit. Accepting outlier patients would reduce the department's flexibility in managing its own patient flow.

Learning from complaints and concerns

- There was information at the reception desk in the main waiting area to inform patients how to make a complaint. Staff also advised us that they give patients who express a concern a PALS leaflet.
- Complaints were managed by the trust, all patients who raised a complaint received an apology from the chief executive.

Are urgent and emergency 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 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 departments' 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 leadership and staff told us they were approachable. All staff told us that the ED had an effective team ethos and culture of transparency.

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 trusts' two EDs. The consultant staff, as they worked across both sites, were an important link in sharing learning from incidents. Three consultants told us that they did not clinically support staff at the Andover minor injuries unit, except for telephone advice.
- Governance meetings were held regularly and were attended by medical and nursing staff. Mortality and morbidity meetings were also now occurring, to ensure that learning occurred.
- Internal audits took place on infection control and environmental checks.
- The department fully participated in CEM audits which were facilitated by a consultant.
- There was a 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 ongoing. 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.

Leadership of service

- Nursing leadership was strong: in addition to the unit matron, the senior nurse clinical lead for ED was based in the department as well as the operational manager.
- There was strong medical leadership from the lead consultant and her team. Junior doctors told us that they felt well supported by the department's consultant team, and would recommend it as a place to work. Medical staff at all levels told us there was excellent team working across roles in the department.
- The leadership team were proud of the warm and friendly atmosphere in the department. All staff we spoke with commented on the team ethos. Staff felt that they were listened to when they raised issues.
- The senior team at the trust (such as the Chief Nurse) was approachable and accessible if needed. Staff reported that the chief executives blog was a useful communication. The nursing staff at all levels told us there was excellent teamwork across all roles in the department.

Culture within the service

- Leaders in the department told us that the priority within the department was patient care and not targets. They were aware of the target breaches, but felt they were mostly caused by bed management issues that were beyond the department's control.
- We found the culture in the emergency department to be open to learning from incidents. The team were supportive of each other and staff felt supported to report concerns.
- Staff told us that consultants worked well with their counterparts in medicine and surgery.
- Many members of the ED team had been nominated for the trusts award scheme either by other staff or patients.

Public engagement

- The 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.
- 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.

Staff engagement

- The staff across the department were highly 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 remained high despite the pressures on the service and the problems with nurse recruitment.

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 trial such as the CRASH 3 and Paramedic 2 Trials. The CTKUB pathway was designed to allow patients with kidney stones (who were well) to be discharged home and be investigated as an outpatient.

Medical care (including older people's care)

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

Information about the service

We inspected medical division services at Basingstoke and North Hampshire Hospital (BNHH), which is a part of Hampshire Hospitals NHS Foundation Trust.

BNHH provides cardiology, gastroenterology, respiratory medicine, endocrinology, dermatology, general medicine and stroke rehabilitation within the medical services. The hospital has a 26 bedded coronary care unit (CCU) which provides care for the more acutely ill cardiac patients.

The hospital also provides services to elderly patients and those living with dementia. There is a 18-bedded acute medical assessment unit (AAU) .

We inspected the AAU, CCU, stroke ward (F1 –Oakley ward), elderly care and dementia wards (F2 and F3 wards), general and speciality medicine wards (E2,E3 and E4 wards) and rehabilitation ward (Firs ward).

During this inspection, we spoke with approximately 25 patients, including their family members, 50 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

Overall, this core service was rated as 'good'.

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

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.

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.

However, most medicines were managed appropriately for safe use. However, the controlled drugs on the Acute Assessment Unit (AAU) were out of date. Infection control procedures were not always followed on all wards and resuscitation equipment was not appropriately checked, stored and up to date on all wards.

There was a significant shortage of nursing staff on the medical and care of elderly wards. The trust was trying

Medical care (including older people's care)

to use bank nurses where shortages were identified. However, we found that safer staffing levels at night were not always met on F1,F3 and E2 wards. Staff on the wards told us this was a risk to patients because these wards had elderly patients with higher risks of falls and patients living with dementia. Medical staffing, across the medical services, was appropriate and covered medical outliers well. The data provided by the trust demonstrated that the hospital routinely had medical outliers and they were regularly assessed and followed by a team of medical consultant and junior doctors.

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 diabetes care and patients who may of had a heart attack. Where outcomes were worse than the England average, for example, for stroke rehabilitation, there was an action plan to address areas for improvement.

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 was one medical outlier 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?

Requires improvement

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

We rated safe as 'requires improvement'.

There was a significant shortage of nursing staff on the medical and care of elderly wards. Staff were working longer hours and the trust was trying to use bank nurses where shortages were identified. However, safer staffing levels were not being met at night met on F1,F3 and E2 wards. Patients on these wards had a higher risks of falls and there were patients living with dementia. The staffing level on this ward had an impact on patient care as staff were unable to undertake preventative measures and the incidence of falls, for example, had increased.

Most medicines were managed appropriately for safe use. However, the controlled drugs on the Acute Assessment Unit (AAU) were out of date.

Staff regularly washed their hands in between patients, used personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbows' policy with the exception of E4 ward (medical ward) where we observed members of staff offering assistance to patients without using the personal protective equipment.

We found random gaps in daily checks of resuscitation equipment on F3 ward. The resuscitation trolleys were not always sealed or tagged. On AAU we found out of date equipment on resuscitation trolleys despite checks being done that day.

Staff described an ethos of openness and transparency in responding to incidents but were not aware of the additional requirements of the Duty of Candour in handling incidents. 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.

Equipment was maintained and checked regularly to ensure it continued to be safe to use.

The environment and equipment were well maintained. Staff had good access to equipment needed for pressure area care were able to order bariatric equipment within 24 hours. Patient records were well maintained and completed with clear dates, times and designation of the person documenting.

Patients were appropriately escalated if their condition deteriorated. 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.

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.

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 we spoke with knew how to recognise and report incidents on the trust's electronic recording system. They were able to give us examples of range of reportable incidents such as accidents, pressure ulcers, medication errors, slips ,trips and falls. Staff stated they were encouraged to report incidents.
- Staff told us they received feedback on the incidents they had reported. Minutes of monthly ward meetings confirmed that the themes of incidents were fed back to staff.
- Themes from incidents were discussed at ward meetings and incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, in response to high number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification of falls by using falls risk assessment and developing comprehensive action plans. Throughout our inspection we observed that the patients at high risks of falls were clearly identified and actions to minimise the risk were taken. For example non-slip socks and low level beds were used on the 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 for falls were displayed in ward areas.
- Learning from incidents was also shared across the trust via the route of trust's monthly bulletin and staff newsletter.
- Medical services held mortality and morbidity meetings on a monthly basis. Records of the mortality and morbidity meetings minutes showed that any death that had occurred in the department was reviewed, root causes analysis following incidents were discussed, and any lessons to be learnt were shared.
- Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a severe or moderate level of harm.
- Nursing 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 and falls.
- The majority of the medical and care of elderly 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 (blood clots). This information was presented in a format that could be easily understood by the general public.
- The safety thermometer audit data demonstrated that between July 2014 and June 2015, for medical services, there had been no consistent reduction in the prevalence rate of new pressure ulcers with periods of both reductions and then periods of increases. 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 made easier. 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
- Between July 2014 and June 2015, the hospital had similar or less number of falls than the national average in most of the months except for May 2015 where the number of falls were above national average.
- The medical division performance and finance report (July 2014 – June 2015) identified that the number of falls was higher than 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.

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 staff were compliant with hand hygiene, isolation procedures and the correct use of personal protective equipment (PPE), such as gloves and aprons on all of the medical and care of elderly. However on E4 ward (medical ward) we observed members of staff offering assistance to patients without using the personal protective equipment.
- 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. The sluice in acute assessment unit (AAU) was overcrowded with two waste bins and cages containing dirty linen and staff had to stretch over these to empty bedpans. This created a risk of spillage and the risk of cross infection.

- There were isolation procedures and protocols in place around the use of side rooms or cohort bays and we observed these being used appropriately. This was particularly observed in the isolation ward where patients with high risks of infections were admitted.
- 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 71% to 100% of staff had completed the training as of June 2015. The compliance of infection control training for medical staff was low at 50% against the trust's target of 80% as of 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 infection control audit in April 2015 had identified non-compliance around urinary catheter care in E3 ward and hand hygiene on the AAU. 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 F2 ward environmental audit (January 2015) demonstrated full compliance with infection control standards with an overall standard of 85% or above.

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. 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 equipment library when required.
- There were daily checks of resuscitation equipment on most of the medical wards and AAU and these checks were documented. We found random gaps in these checks on F3 ward. The resuscitation trolleys were not always sealed or tagged. This meant that the resuscitation trolley could have been opened and thus may not be fully ready for emergency use. In AAU we found out of date equipment on resuscitation trolley despite checks being done that day.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges when necessary. Checks on the temperature of medicines fridges were completed daily on most of the wards we visited except on AAU,E2 and E4 wards where gaps in the daily checks were identified.
- Controlled drugs were mostly managed and stored appropriately. However, we were unable to establish when the pharmacists had last checked the control drugs on AAU. On AAU we found out of date medicines and out of date yoghurts stored in the medications fridge.
- There was a good system of electronic prescribing across the trust. Staff we spoke with told us the support from pharmacy service was good. AAU 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 medicines incidents which happened on their wards and the learning they took from these incidents.

- Patients' medication charts clearly identified any known allergies to reduce the risk of being given inappropriate medication.
- Patients told us they were usually given their medicines on time. They also said medicines were explained to them and they were told about risks associated with taking medication.
- We observed staff giving patients medication only after correct checks were made. Nurses undertaking drug rounds were protected from interruptions. Staff had good access to information about medicines.
- The trust antimicrobial prescribing policy was being adhered to for outliers.

Records

- 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 set of patient records. The trust was aware of this and had plans to introduce a combined set of patient records.
- We reviewed approximately 22 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 they were reviewed regularly by medical consultants and junior doctors.

Safeguarding

- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constituted 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; 85% of nursing staff working in medical services had completed adult safeguarding training as of June 2015.The percentages of medical and dental staff completing the same training in medical services which was a part of medical services was approximately 41%. 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. 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 41% 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 amongst medical staff group.

- 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 completed 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 AAU 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 AAU 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 severe 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. There were arrangements for staff to access a critical care outreach team between 8am to 8pm, Monday to Friday, to support and advise in the care of very sick or deteriorating patients. Staff across all wards stated that this service was responsive and supportive to staff and provided a high standard of clinical specialist knowledge. The night staff felt supported by 'night on call' team and told us their support was valuable and helped in the provision of safe care.
- There was only one medical outlier 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. We followed this up during the unannounced inspection and observed that nursing and medical staff were clear about where the outliers were, and the plans to follow them up.

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 25% vacancy rate for the registered nurses across cardiology service ,22%for registered nurses across care of elderly and stroke wards and 14% for registered nurses for cancer services. Nursing staff turnaround rate between April 2014 to April 2015 was approximately 27% for medical wards and 15% for 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.
- 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. However, 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 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 and planned staffing levels were not met on E2 ward on 23 night shifts, for 6 night shifts on F3 ward and for 17 early shifts on F1 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 make up numbers as the trust was not able to fill the vacancies using the bank staff .Staff on the wards told us this was not safe for the patients. For example; F1 ward which was a stroke rehabilitation and E2 ward which was a medical 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 E2 ward had 42 falls with low harm between January 2015 to June 2015. The ward was a 24 bedded ward and had one nurse and 2 HCAs at night. Staff reported that there were four additional falls in the ward in the week before our inspection.
- Staff on the medical and care of elderly wards told us they were often requested to attend other wards or AAU where there were shortages in staffing level. They found it very unsettling as this was happening routinely. For example; staff on the E3 ward (respiratory ward) told us that they often were requested to attend other medical wards as the ward had full establishment for the nursing staff. This ward had four bedded area which was used for acutely ill patients who needed close monitoring (level 1 patients). These patients had complex needs and often required a non-invasive mode of ventilation. Staff told us that on occasions there could be up to six patients who were categorised a level 1. The staffing rota for month of June 2015 showed us that the staffing level on this ward was met most of the time. Staff however told us as they frequently were requested to attend other medical wards, this staffing ratio did not meet patients' needs and was sometimes a risk to patient's safety due to the complexity of the patients in this unit.
- The staff on the wards 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. However, this could not be sustainable.
- 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 a number of wards.
- 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 of 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.
- The trust had plans to make certain changes around the overall nursing structure by making the senior nursing staff more ward based and clinical to enhance overall quality outcomes.

Medical staffing

- There was a consultant cover on the AAU from 8am – 4pm seven days a week. Consultant ward rounds on AAU took place twice a day. During the day all new patients on the AAU 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 AAU 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 higher number of medical consultants and junior doctors as compared to national level. As of June 2014, the vacancy rate for care of gastroenterology consultant or equivalent grades was 31% and that for general medicine was 1%.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 AAU, in line with the above guidance.
- On the medical and care of elderly wards patients were seen by a consultant twice a week by a consultant. Over the weekend, there were two on call consultants who saw all new patients and acutely ill patients on AAU and medical wards.
- Nursing staff told us that medical patients who were on surgical wards were regularly reviewed by seen 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 diabetes care and patients who may of had a heart attack. Where outcomes were worse than the England average, for example, for stroke rehabilitation, 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. Although patients were not always supported to eat and drink by 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 management of diabetes, heart failure and pressure ulcer prevention.
- Policies were accessible for staff and were developed in line with national guidelines, such as the pressure ulcer prevention and management policy. Staff we spoke with were aware of these policies. Patient records we reviewed showed risk assessments and care plans for patients who were at risk of developing pressure ulcers.
- There were integrated care pathways based on NICE guidance for patients admitted for stroke rehabilitation.
- There were specific pathways and protocols for a range of conditions, including diabetic ketoacidosis, heart failure, and respiratory conditions. The trust had a pathway for patients with sepsis and acute kidney injury to enable early recognition, prompt treatment and clinical stabilisation.
- The endoscopy department had been awarded Joint Advisory Group accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance.
- The medical services participated in all national clinical audits that it was eligible for, to measure the effectiveness of care and treatment provided. The audits included a heart failure audit, the Myocardial Ischaemia National Audit Project, the Sentinel Stroke National Audit Programme and the National Diabetes Inpatient Audit.
- The medical services had a formal clinical audit programme in which compliance with NICE guidance was assessed and the areas that had partial compliance were reviewed and action plans were made. 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.

Pain relief

- We observed nurses and doctors monitoring the pain levels of patients and recording the information. Pain levels were scored using the National Early Warning Score (NEWS) chart.
- For patients who had a cognitive impairment, such as dementia or a learning difficulty, staff used the 'Abbey Pain Scale' to aid their assessment. This scale was developed for patients with communication difficulties who were unable to verbalise how much pain relief they 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.

- There was a patient group directive for nursing staff to prescribe pain relief.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the medical wards. We observed that fluid balance charts were used 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 accordingly if patients did not have a safe swallow reflex. Instructions from speech and language therapists were recorded in patients' records and care plans.
- A 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 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 were visiting these wards.
- Patients told us they were always given choices for food and snack menu. Most patients were highly complimentary about the quality of food provided. One patient commented that "Food is great. I'm a diabetic but I have good choice of food menu".

Patient outcomes

- The hospital's mortality rates were within the 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. BHNH provided stroke rehabilitation. The combined indicator for BNHH was level D (October 2014 to December 2014) which was below, but not worse than the average (A being best and E being the worse) and was similar 44% 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 discharge processes. The hospital was similar to other trusts for care on the stroke unit, physiotherapy and standards for discharge and was below average for occupational therapy and 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 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 rehabilitation ward.
- The hospital participated 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 team. The hospital performed below the national average in non-ST segment elevation myocardial infarction patients that were referred for or had angiography.
- The trust'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 general medicine where they were significantly 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 cardiac care in its performance report. Overall the trust was meeting the target for 100% patients requiring emergency cardiac care to reperfusion and a call to balloon time of 150 minutes (there were three out of 12 months when the target was not met) and door to balloon time of 90 minutes (there was one month out of 12 months when the target was not met) (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. The appraisal completion rate for nursing staff who were band 7 or below was between 33% to 88% 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. 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 (F1 ward) had recently participated in an 'away day' where staff participated in various educational activities related to stroke and also attended 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 had the training to ensure they had the specialist skills required to offer specialist interventions. For example; nursing staff on E3 ward (respiratory ward) had attended a training programme on tracheostomy and non-invasive ventilators run by the British Thoracic Society and were encouraged to attend 'acute patient deteriorating course' which was run by the trust. Nurses reported concerns that on occasions staff shortages prevented them from attending training.
- Nursing staff told us that due to staffing shortages, occasionally they had to compromise on training in order to make sure they always delivered safe patient care and the quality of care was not impacted.
- 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 band 5 physiotherapist on stroke ward was undertaking MSC module from Southampton university which was supported and funded by the trust.
- 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 felt the 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 form the

stroke team worked across Royal Hampshire County Hospital (RHCH)and Basingstoke and North Hampshire Hospital (BNHH).This allowed in improving 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 medical wards. 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 AAU, 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 twice 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. These meetings were attended by consultant geriatricians, junior doctors, physiotherapists, occupational therapists, nurses, student nurse, dieticians and discharge coordinators.
- There was dedicated pharmacy support on all the wards we visited.
- Geriatric 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 AAU 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. Patients who were admitted to stroke ward (F1 ward) were seen by the consultants twice a week. The transient ischaemic attack clinic was accessible Monday to Friday and patients were sent to Royal Hampshire County Hospital should they need input from the TIA clinic over the weekend.
- There was a daily consultant gastroenterologist on-call for emergency gastrointestinal (GI) bleeding patients. There was a seven-day endoscopy service available for GI bleed patients.
- There were arrangements for staff to access a critical care outreach team between 8am to 8pm, Monday to Friday, to support and advise in the care of very sick or deteriorating patients. This service was available for limited hours over the weekend.
- 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 seen 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 and this ensured that 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 about 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.
- 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.
- The hospital was trialling out new capacity assessment forms on care of elderly wards and stroke ward (F1,F2 and F3).We reviewed patient care records on these wards and found that the capacity assessments were detailed and comprehensive and were clearly able to outline whether the decision was made in patient's best interest where they lacked the mental capacity.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Most of the 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. At the time of our inspection six patients on F1 ward (stroke ward) had Deprivation of Liberty Safeguards (DoLS) in place. The capacity assessment was completed for these patients however we found that the DOLs authorisation had expired for two of these patients. We informed this to the senior nursing staff on the ward who immediately applied for the extension for authorisation of DoLS safeguard to local authority. This meant that the process for DoLS was not robust and patients were at risk of being detained unlawfully.

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 good 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 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.

Patient's emotional needs were highly 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. 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. The average trust score for medical wards was almost similar to the England average.

- 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 25 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.
- 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 care is marvellous here." One said, "I could not fault the care one little bit." A patient's relative in the AMU told us, "We are really impressed with the care and the attention to detail that is given by nurses and doctors toward our mother."
- We observed multiple examples where staff demonstrated compassionate and kind behaviour towards patient. 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.
- Both patients and their relatives commented that information was discussed in a manner they understood. Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. 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 and cardiac ward 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 written in user friendly language which encouraged the patient to take ownership of their own goals.
- The trust encouraged carers and relatives of patients living with dementia to stay with their loved ones while he or she was an inpatient on the ward by offering them a carer's passport. The carers were encouraged to support 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 multiple episodes of kindness from motivated staff towards patients and their relatives.
- 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 around the hospital and were happy to meet people to offer them support.
- We observed eight patients from the Firs ward (rehabilitation ward) and other care of the elderly wards

having a social coffee morning which had been organised by the activity co-ordinators. The patient told us that "we enjoy coming here so much! It's not like we are in hospital for an hour. It makes us feel normal".

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 assessment unit (AAU) which also had GP admission bay 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% for the period between April 2013 to December 2014 which was below the England average of 88%. The data provided by the trust demonstrated that the hospital routinely had medical outliers and they were regularly assessed and followed by a team of medical consultant and junior doctors. There was one medical outlier (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. 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.

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

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 and although many were not dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved. Patients we spoke with felt they would know how to complain if they needed to.

Service planning and delivery to meet the needs of local people

- The 18 bedded AAU 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. 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 AAU for assessment and diagnosis of their condition with a maximum stay of 24 to 48 hours. If a longer stay was required, patients were transferred to the relevant speciality ward. However, because of bed pressures patients were frequently cared for in the AMU for longer periods.
- The patients admitted in the AAU 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. Patients with diabetes who were admitted on AAU were regularly reviewed by a diabetes specialist nurse.
- The AAU had a separate bay with six chairs 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 majority of their caseload. Staff told us the GP admission bay 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 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.

Medical care (including older people's care)

- Input from specialist nurses was available for patients on medical wards such as diabetic specialist nurse, respiratory link nurse and heart failure nurse.
- The CCU had appointed a pharmacist exclusively for their department who worked on the unit and cardiology ward three times a week. Staff told us the pharmacist's input had helped in accelerating the discharge process.
- The cardiology unit offered a primary angioplasty service seven days a week in the cardiac catheter lab and also had a coronary care unit and a cardiac rehabilitation ward. The unit had closer links with Royal Brompton Hospital (RBH) where patients were referred for surgery if required. The consultant electrophysiologist from RBH visited the hospital on a quarterly basis for specialist input.
- The trust offered a comprehensive cardiac rehabilitation service operates across 4 sites: Alton Cardiac Rehabilitation Centre; Basingstoke and North Hampshire Hospital (BNHH); Royal Hampshire County Hospital and Andover War Memorial Hospital. This service was delivered by a team of cardiac rehabilitation specialist nurses, physiotherapists, and exercise Instructors and covered all aspects of the rehabilitation pathway. Inpatients at the BNHH were assessed and given advice in CCU after their heart attack and were followed up by telephone and then offered an individually tailored outpatient or home exercise programme. Referrals to this service were also taken from GPs and tertiary centres for valve and bypass patients and stable heart failure patients from the heart clinic wishing to attend the rehab programme. We were told by a patient and their relative in CCU they had already been contacted and reviewed by the cardiac rehabilitation team. The patient thought this service was 'impressive'.

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 AAU 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 AAU to speciality wards.
- The average length of stay in the AAU was aimed to be 24 to 48 hours. However, staff told us that this was frequently not achieved and many patients stayed in the AAU up to a week because it was difficult to transfer these patients to the speciality wards because of capacity issues.
- There was only one medical outlier 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 that between June 2014 to June 2015 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. The 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.
- Staff told us that bed moves happened all the time. Bed moves were monitored at the ward level and centrally at the trust level. Data provided by the trust demonstrated between April 2014 to March 2015, 24% of the patients had moved wards at least once, 9% of the patients had moved wards at least twice and 4% of the patients had moved wards more than three times during their hospital stay. Where ever 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 trust's performance report between July 2014 to June 2015 showed that an average of 160 patient moves took place per month between 10pm and 7:59am at this hospital.

Medical care (including older people's care)

- The medical services were consistently achieving the 18-week referral-to-treatment time target against the national target 90% (April 2013 and February 2015).The compliance rate for geriatric medicine and neurology was 100%. The incomplete pathway target for 92% of patients to be waiting for less than 18 weeks was also achieved.
- The trust met the 31-day cancer waiting time diagnosis-to-treatment target. The trust had met the 62-day waiting time target from referral to treatment (April 2013 and February 2015). This 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 were an increasing number of delayed discharges and transfers of care.
- We were told that the main cause of delays was the provision of community services, especially care home placements, to meet patients' ongoing 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 needs were assessed by in reach team from Southern Health Foundation NHS 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 16 bedded Firs ward. Patients who were medically fit for discharge but were awaiting social care packages were transferred from care of elderly wards to Firs 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 medical services had discharge facilitators who supported ward staff to fast track discharges. They assessed for simple discharges and case managed complex discharges with commissioners and partners, such as the local authority and in-reach co-ordinators from the local community and mental health trust. They also carried out specialist assessments along with social workers such as those for NHS funded continuing care and best interest decisions.

Meeting people's individual needs

- We observed on AAU that the ward was divided into two sides, one for females and one for males, and then split into three bays. There were two side rooms on each side. Staff told us that the opposite sex were frequently placed in these side rooms. On our inspection we observed a male patient who walked from the side room across the female bay in their night attire to use the toilet as the toilet in his side room was not in working order. This had resulted in the environment not completely meeting the needs of patients; for example, female patients were placed in bays on the male side. Staff told us this had frequently compromised patients' privacy and dignity, as patients had to walk in their gowns from their bed to the toilet.
- We observed elements of dementia friendly design was incorporated into the care of elderly ward areas, for example colour coding system was used for different bays and pictorial signage being used.
- 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 the booklet and it was appropriately completed. A 'sunflower' symbol was used to identify people living with dementia on all the care of elderly and medical wards.
- 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.

- 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 disorder.
- Staff were able to access support and advice 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 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 patient literature was displayed in clinical area covering disease and procedure specific, information, health advice and general information relating to health and social care and services available locally. Patient information leaflets were not displayed in languages other than English.
- 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 made them feel the hospital was a homely environment**.**

Learning from complaints and concerns

- The medical services monitored both complaints and concerns. The medical division performance and finance report (April 2014 – March 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, and staff showed us that patients were given information on how to complain. Staff directed patients to 'Patient Advisory Liaison Service (PALS)' if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint, formally or informally.
- Where patient experiences were identified as being poor, action was taken to improve their experiences. Staff told us that any learning from complaint investigations was shared with the team. The trust's monthly newsletter also shared lessons learnt from concerns and complaints across the trust.

Are medical care services well-led?

Good

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

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

Medical care (including older people's care)

Staff felt proud to work for the trust. Staff, including student nurses, doctors and housekeeping staff spoke passionately about their work and of being part of the team.

The strategy for the medical services 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;Royal Hampshire County Hospital (RHCH) and Basingstoke and North Hampshire Hospital (BNHH) and potentially at the planned critical treatment hospital (which the trust had planned to develop in near future) 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 a 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 the medicine was good.

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

Patient feedback was collected and used in planning many of the services we visited. These

included patient survey feedback and learning from complaints. The stroke rehabilitation ward (F1)) held a 'breakfast club' in the ward for patients. This was to promote patients' independence, gain confidence and also incorporated social interactions and therapy sessions.

The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service.

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 patient journey and treating patients in the most appropriate area and specialism, developing a frailty unit for care of elderly patients and to further improve and expand 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 agency to assist in identifying challenges related to patient 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. They 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 audit, incidents, complaints and patient feedback were discussed and shared with staff. Minutes of clinical governance meetings showed patient experience data were also reviewed and monitored.
- 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 the matron was visible and had a regular presence on their ward. Staff told us that the Chief Nurse was approachable and helpful. Staff in the CCU were in particular, highly complimentary about the leadership of the unit.
- 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 accessible. All the staff spoke highly of the chief executive.
- Staff told us the medical service leads had a visible presence on the wards and provided good leadership.

Culture within the service

- Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Front-line staff worked well together, and there was obvious respect 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 staff spoke passionately about their work and of being part of the team. One senior nurse described working for the trust as a "an enjoyable experience and feels like home"**.**

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.
- The stroke rehabilitation ward (F1)) held a 'breakfast club' in the ward for patients. This was to promote patients' independence, gain confidence and also incorporated social interactions and therapy sessions. Patients told us they found these sessions beneficial. One patient said; "it's great to be able to make a cup of tea knowing that I am safe "
- Clinical governance meetings showed patient experience data was reviewed and actively monitored.

- The CEO of the trust had an 'open door ' policy and service users were encouraged to contact the CEO directly to express their views and suggestions about delivery and improvements of services in the hospital.

Staff engagement

- The trust was taking the initiative to engage and integrate staff across the trust's three main locations by creating different opportunities. Information was sent to staff regularly by email and the trust's monthly newsletter'. Staff were encouraged to look at the staff intranet. Band 7 staff had regular meetings across all the three hospitals which gave them opportunities to share practices and learn.
- Staff's views and experience were being 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.
- NHS staff survey results from 2014 showed the trust's performance was rated within expectations for 28 out of 31 indicators. The trust performed worse than expected for 2 out of 31 indicators. The Areas in which staff did not feel the trust performed well were staff working extra hours and staff reporting errors, near misses or incidents witnessed in the last month. The trust performed better than expected in one indicator which was staff agreeing that they would feel secure raising concerns about unsafe clinical practice
- 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 many examples of innovation and good practice.
- 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 wards had an activity coordinator who planned and conducted different activities for patients after consulting them. The activities included a range of things such as arts and craft, music, dance, group lunches and movie time. We observed patients participating and enjoying these activities on care of elderly wards and stroke ward.
- 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 was holding an event to focus on exploring CIP rich environments 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.
- The service leads considered 'safety and quality' as a priority in the CIPs and had an approach 'spend money to earn money'. For example; the medical staff told us that they got a say on preferred consumables 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

Basingstoke and North Hampshire Hospital provides emergency and elective surgery for a range of specialties for patients requiring trauma and orthopaedic, ophthalmology, colorectal, urology, ear, nose and throat (ENT), maxillofacial and gynaecology and general surgery. The hospital has a main theatre suite, with seven theatres. There are further theatres in the diagnosis and treatment centre (DTC) a modern planned care centre, within the eye day care unit and the private patient unit, run by the hospital. Patients are cared for across 10 wards.

Between January and December 2014, there were 14,131 hospital surgical episodes (data that identifies the continuous stay of a patient using a hospital bed) at the hospital, 35% of which were trauma and orthopaedic, 26% general surgery, 23%ophthalmology and 17%other. Day case accounted for 39%, elective surgery31% and there were 30%emergency spells.

During our inspection of the surgical directorate we visited 10 wards, the pre-assessment unit, the admission lounge, the day surgery units, operating theatres and post anaesthetic care unit at the hospital. We spoke with approximately 42 patients, relatives/visitors and 56 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, dieticians, therapists, pharmacist, pharmacy assistants and senior management.

We observed care and treatment and viewed 43 cares 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

This core service was rated as 'good'. We found that surgery was 'Good' for effective, caring, responsive and well led. We rated safe as requires improvement.

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. Some patients did not have their medication at the required time. There were not always adequate numbers of nursing staff to meet the assessed needs of patients.

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 95 - 99%. The early warning score was not consistently being used to identify patients whose condition might deteriorate. 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 was good leadership at local levels. 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. Bank staff were used to cover shortfalls but staff were not always available and were working longer hours. Senior nursing staff indicated that the escalation process could be unnecessarily lengthy. The trust was implementing actions to mitigate and reduce these risks but we observed on some wards, patient's needs were not being met.

Resuscitation equipment had not been appropriately checked in line with trust policy. Infection control procedures were not always followed. On one ward staff, for example, had not used protective equipment to mitigate the spread of infection.

Medicines were mostly managed appropriately and in accordance with medicines guidelines. However this was not consistent, on one ward patients did not always receive their medicines at the required time. Medicines stored in fridges were not appropriately checked. Patient Group Directions, which allow trained nurses to prescribe and drugs were not signed appropriately.

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. .

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 95% - 100%.

Surgical staffing levels were appropriate.

Incidents

- Data and information received from May 2014 to June 2015 showed there were no "never events". A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented. The incidents of "never events" were reviewed by the surgical quality group, a root cause analysis (RCA) completed and learning shared across teams.
- The trust reported 15 serious incidents between May 2014 and April 2015, through the National Reporting and Learning System (NRLS). These included hospital acquired pressure ulcer grade three and four, slips, trips and falls.
- 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 practise at team meetings. For example, following an increase in vancomycin resistant cases (VRE) a root cause analysis (RCA) was undertaken including observations of staff' practices and feedback provided. The action plan included screening of all patients on admission to critical care and appropriate measures put in place at Basingstoke. The trust plan to introduce this across all sites from August 2015.
- 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.
- The trust had developed a policy which was signed off by the chief executive in May 2015. The policy talked about the trust statutory requirements and the "Being Open process." Senior staff we spoke with were not aware of this.

Safety thermometer

- The trust collected safety thermometer data in relation to care provided to patients. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, venous thromboembolism (VTE), catheter-related urinary tract infections and falls. Safety thermometer information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- The incidence of falls on D4 ward, showed that between February 2015 and June 2015, there were a total of 19 falls;11 were classified as causing harm to the patient.
- For Ward D3 there were 26 recorded falls between January2015 and June 2015. These included 4 falls with low harm and 2 severe harm. Ward minutes showed these had been discussed at team meetings and review of procedure had taken place. There was a low incident of catheter related urine infection with only one incident in the last eight months.
- Monthly audits were undertaken by each ward looking at the percentage of patients who received harm free care. This information was reported on at the division governance meeting. The compliance with the trust target of greater than 95% was adhered to for most wards, however specific concerns were identified for two wards.
- On Ward D4 they had achieved 60% compliance with the most recent urinary tract infection catheter audit and ongoing care audit and 70% compliance with the cannula care audit, both were completed in July 2015. This was below the trust set target of over 95%; senior staff said that in response to this audit, additional reminders would be issued to staff at team meetings. Other wards had higher level of compliance.
- The national harm free care rate data from NHS England for the period from April 2014 and 31 March 2015 showed the trust performed well and had achieved 93% harm free care against their target of 95%.

Cleanliness, infection control and hygiene

- Wards were visibly clean and infection control procedures were in place to prevent the spread of infection to patients, such as hand sanitizer points. Instructions and advice on infection control were displayed for patients and visitors, including performance on preventing and reducing infection. On D4 there was no hand sanitizers available at the entrance or outside the main entrance to the ward which could pose infection control risks.
- We observed staff following hand hygiene procedures such as washing their hands and using sanitizing gels as part of infection control. Theatre staff were issued with "scrubs" for use within the theatre area and we noted staff adhered to infection control procedures.
- Hand hygiene audits for surgical services from August 2014- toMarch2015 showed between 92% -100% compliance against the trust target of 100%. We saw that results and action points were discussed with staff at team meetings.
- Staff did not always follow effective infection control practices such as protective personal equipment (PPE) were not used when dealing with infected materials on D4.
- The management of infected materials was not always effectively managed on D4. The sluice room door was found to be open on three separate occasions during our visit. Infected materials were found in boxes on the floor which could be accessed by patients and visitors and were there for over four hours.
- There were no holders for urinals on all the wards which meant used urinals were placed on the tables where patients had their drinks. We brought this to the attention of a senior staff who confirmed they did not have holders and this would be addressed.
- Staff told us that hoists slings were shared among patients, as patients were not allocated individual slings, however slide sheets were. Staff were not able to tell us about the procedure to prevent cross infection from shared slings and staff could not confirm if these slings were cleaned between patients.
- The trust had set their clostridium difficile (C.diff) trajectory for 2015-2016 at 34 cases; they were 16 cases

at the end of June 2015. There were systems in place to prevent the spread of infection to other patients such as medical assessments had to be completed within four hours of an outbreak. The microbiology laboratory have changed their process to inform the bed manager and the medical registrar of all positive C. difficile tests out of hours in order for appropriate actions to be taken sooner.

- Staff followed procedures for screening patients for MRSA pre-operatively or on admission if they were unplanned admission.
- During the period of between March–June 2015 there was no reported incident of methicillin resistant staph aureus (MRSA). There were two incidents of 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.
- There was one incidence of Norovirus between April 2015 and - 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.
- The Infection Control root cause analysis (RCA) panel met at both the Basingstoke and Winchester hospitals. Two panels a month were held to review any patient who had acquired a healthcare associated infection (HCAI).
- Surgical sites infection rates for total hip replacement was same as the national average at 1.2% for the months of January –March 2015. The bed pan washer was out of order for 23 days and was still not working during our inspection; the fault had been reported in July 2015. Bed pans were being washed and sterilised by hand. There was no procedure developed to ensure safe infection control practices were followed such as use of PPE as we observed staff did not use PPE while they were hand washing bed pans. The bed pan washer was mended on the day of our unannounced inspection.

Environment and equipment

- Emergency equipment was available and there was a process for servicing all equipment to ensure it remained fit for purpose. A random check of a number of pieces of equipment showed they were within service date.
- There was a process on each ward and in theatres for the resuscitation trolley to be checked daily, which was adhered and this was carried out on C level, in Eye Day Care Unit EDCU and theatres. The resuscitation trolley had not been checked on a daily basis in accordance with the trust guidance on D4 and D3. The staff told us they had been too busy. This may pose a risk that equipment may not be available or fit for purpose if needed in an emergency.
- Cleaning chemicals stored in the sluice was not managed safely on D4, which could be accessed by patients and others as the door was not kept closed.

Medicines

- On D level staff told us due to staffing shortage, patients did not always receive their medicines at the appropriate time and included medicines for diabetes. Medicines rounds were taking up to three hours and staff could not be assured patients received their medicines at the appropriate times. Nursing staff were interrupted during the medicines round. No red bibs were used to show staff were administering medications and should not be disturbed.
- Medicines were stored according to manufacturer's guidance and dedicated refrigerators were available for storage of some medicines. The fridge temperatures were monitored and in the Eye Day Care Unit (EDCU), all eye drops were stored safely. However this was not done daily on some of the wards, nor was the minimum and maximum temperature recorded. This meant staff did not know when the fridge temperature was either above or below the normal range. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients
- Appropriate systems, processes and policies were in place for the storage, administration of medicines, including the management of controlled drugs given to patients. A record was maintained of medicines given to patients to take out (TTO's).
- A pharmacist and a pharmacy assistant were allocated to the wards. They undertook regular reviews of patients' medicines and provided staff with advice such as drug dosages and contraindications and assisted with patients own medicines on admission, This ensured patients had their medicines when they needed them .

- Registered nursing staff in the Eye Day Care Unit (EDCU) administered three different types eye drops against a patient group direction (PGD). A PGD provides a legal framework that allows registered nurses who had completed appropriate additional training and signed the PGD to supply and/ or administer a specified medicine (s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety.
- Although the PGD's were in date, these were not signed as per the trust policy by any staff using the PGD to administer the eye drops. We raised this with the trust who provided us with further information; the PGD's received were for two of the three drops currently being administered. The documents were updated in 2009, but there was no implementation or review date, there were no signatures on these documents.
- Although the legislation gives no time limit for a PGD to be reviewed, HSC 2000/026 (NHSE, 2000) requires a review every two years for England and the royal college of nursing (RCN) recommends this as good practice throughout the UK. .
- Medicines were stored safely and securely in theatres.

Records

- We reviewed 56 medical, nursing notes and other associated records as part of the inspection. We looked to see if the records were stored securely andat the quality, access 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 for patients undergoing elective surgery.
- Policies for the prevention and management of pressure injury were in line with national guidelines. All patients had the Waterlow score which is a standardised assessment for risk of pressure injury completed on admission.
- Risk assessments such as pressure risks, falls and venous thromboembolism (VTE) were completed by nursing staff. A review of 27 VTE records showed these were completed except for those patients admitted with 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) should be used at each stage of the surgical pathway, from when a patient is transferred to theatre until they return to the ward. These were appropriately completed in the records seen.
- Following an investigation into surgical infection rates, the importance of accurate documentation in both the medical and nursing records was highlighted an area of notable practice was noted regarding good note taking for both Medical and Nursing records.
- Patients had a comprehensive pre-assessment which was recorded in the pre-assessment care pathway document and placed in the patient's main hospital notes once completed. If a patient's hospital record could not be found for their pre-assessment appointment, the last few clinic letters were obtained and a repeat history taken by the nurse. The patient's GP was also contacted if there were specific medical concerns. No audit was undertaken of missing notes for pre-assessment appointments.

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, at this hospital, had completed safeguarding adults and children training, for the period April 2014 to March 2015, compared with the trust target of 80%. In two areas, data showed no staff had completed safeguarding adults or children training; professional scientific and technical staff in the pain unit and allied health professionals in orthopaedics.

- One ward was noted to have information for patients and carers on display about how to raise a safeguarding concern relating to a vulnerable adult.
- 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, at this hospital, 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.

Assessing and responding to patient risk

- There were five cases of VTE between March and June 2015 which was below the expected number of four a month. The trust was achieving between 94%-96% of patients who had their VTE risk assessments completed on admission against a monthly target of >95%.
- 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. In surgery, patients were assessed on admission for their risks venous thromboembolism (VTE). Depending on their risks patients were prescribed treatment for the prevention of thromboembolism.
- Staff followed guidelines for the prevention and management of pressure injury. Patients had their "Waterlow" score measured, which is a standardised assessment for risk of pressure injury completed on admission; however there were gaps in reviewing these in some records.
- The surgical wards used the national early warning score (NEWS) to identify if a patient was deteriorating. Staff were aware of actions to take when patients' scores fell outside expected boundaries. However, we saw that NEWS records were not always fully completed or completed on a regular basis on the surgical wards.
- Handovers were well managed and occurred at shift changes with a multi- disciplinary team approach.
- Staff were supported by doctors when they reported deterioration in patients and emergency procedures were instigated as needed.
- Senior staff told us they did not have outliers (patients with non surgical conditions) in surgical wards.
- 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 22 of the patients' records we checked.
- Five Steps to Safer Surgery (based on the World Health Organization (WHO) surgical checklist) is guidance to increase safety for patients undergoing surgical procedures. The guidance sets out what 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. The hospital audit (January to March 2015) of the Five Steps to Safer Surgery checklist showed 100% compliance in trauma theatres, 99% compliance in elective theatres and over 95% compliance in emergency theatres. Surgical staff engagement and leadership was identified as a continuing area for improvement.

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) and 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.
- On all of the wards we visited, senior staff said staffing was reviewed regularly, as there were constant changes to patient numbers, which affected the staffing required and therefore staff were moved around. The actual staffing numbers were displayed in most of the wards but not on D3 and D4 when we visited.
- Staffing numbers for the elective surgical wards were planned through review of the surgical lists, the type of procedure being performed and the skill mix of nursing staff needed to care for the patients.
- The safer staffing data as published by NHS choices published between January and April 2015, showed the trust achieved 89% to -92% of registered nurses hours filled as planned.
- On night duty during the same period the trust had achieved 92% to-94% registered nurses hours filled as planned.
- The safer staffing data for the month of July 2015 for wards D3 and D4 showed the trust was not meeting their nurse to patients' ratios and this was consistently between 1:10 -1:11 trained nurses to patient.
- 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. Ward D3 and D4 dashboard data consistently showed for April 2015 to June 2015 that total staffing levels on day shifts did not meet the required staffing level, for an average of 30-40% of shifts.
- Ward D4 was funded for and staffed for 16 beds. Staff reported the ward had run in escalation mode for a number of months. This was confirmed by data from the trust, which showed for the three months prior to the inspection, the number of patients exceeded 16 on 77 out of 91 days. This caused additional pressure to staff to deliver safe care, due to the staffing shortages.
- Staff told us on some shifts there were not enough staff to provide one to one care to patients who were at high risk of fall. During the inspection, patients requiring 1:1 care did not always receive this, as staff would cover for an hour, but were also needed to provide care for other patients on the ward. We observed a number of occasions where confused and patients were getting out of bed and pulling on their catheters. Staff tried their best to support these patients and said there were "struggling" to cope due to the acuity of patients and those who would benefit from 1:1 care. Patients also told us they did not always receive pain relief in time, staff always apologised and said they were short staffed. There were noticeboards for planned and actual staffing levels which were displayed on each ward. However, on some wards this information had not been completed on the days that we visited. Senior staff confirmed they had not achieved their planned staffing levels on these days.
- Physiotherapy and occupation therapy staff raised concerns that insufficient nursing staff meant they were supporting patients with personal care. This impacted on the time they could spend offering rehabilitation to patients. The use of bank and agency staff made it difficult to keep continuity of care and ensure patients received all aspects of their therapy programme. Staff shortages impacted on the time patients spent out of bed as part of their therapy programme as there were not enough staff to do regular observations or put patients back to bed when needed.
- 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.
- The staffing levels on D1 ward had been reviewed and three nursing staff had started to work on a rotation basis on D3 and D4 wards and the orthopaedic ward at the Winchester site, due to shortages of trained staff on these wards.
- The number of beds on D1 ward had been reduced in response to this change, with an increase to the staff to patient ratios. Minutes were seen advising staff of this change and the importance of reporting as an incident any concerns around unsafe staffing. Regular reviews of patient data were planned to assess the impact on planned elective surgery on D1 ward.

Surgical staffing

- The current medical staffing data showed there were 37% consultants, 14% middle career doctors, 30%

registrars, and 18% junior doctors. Surgical consultants told us they were staffed appropriately with the right skill mix. The trust had a lower registrar group at 30% compared to England average of 37%. They had higher middle career compared to England average of 11%. Junior doctors felt supported and told us that they could contact senior clinicians including surgical consultants if they required advice or guidance.

- However, in trauma and orthopaedic, junior doctors said it was sometimes difficult to access support when the registrars were busy in theatre. There was a ratio of one SPR supporting six junior doctors, which staff felt was not adequate.
- Consultants were present in theatre for complex trauma cases at all times.
- Junior doctors said training was good and included fortnightly protected training; although they were not always able to attend due to work load.
- Handovers were consistently formal and structured. During our announced visit we attended a medical handover. The handover covered care of patients based on the severity of their condition and any anticipated problems.
- Surgical consultants who were on call did not undertake elective surgery which meant they were available for emergencies and to support the team.
- Surgical consultants from all specialties were on call for a 24 hour period. Consultant's ward rounds took place twice a day. New patients were seen by a consultant following their admission during the day.
- 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 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.
- The wards on D floor had an escalation plan in place. This contained detailed information and flowcharts for staff to follow should one or more of the wards become full and how the throughput of patients should be managed and which ward they should be cared for on. A staff member told us that staff tried to work on either the elective (planned) or emergency ward to prevent the spread of infection to patients admitted for elective surgery.

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 ward rounds seven 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.

Surgery

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 aware of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) and guidance were followed. Patients' needs were assessed and pre assessments were completed for elective surgery.

Evidence-based care and treatment

- Staff provided care and treatment to patients based on national guidance such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons Emergency Surgery Guidance.
- 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.
- Emergency surgery was managed in accordance with guidance/ guidelines from National Confidential Enquiry into Patient Death.
- The Royal College of Surgeons' standards for emergency surgery/surgery out of hours were consultant led and delivered. Trauma and orthopaedic hip and knee pathways were used and appropriately completed.
- 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.
- There was audit programme for surgery for the year 2014/15. Of the 93 projects identified across the trust, the hospital was involved in 64. The majority of audits did show completion dates as expected with action plans. Although 34% 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 BNHH included pain management and day case laparoscopic cholecystectomy.

Pain relief

- There was a process for the assessment of patients' pain using a recognised pain assessment tool. We observed patients were asked and offered pain control during the medicines rounds and records were maintained.
- On C and D levels, patients were positive about their pain management and described various type of pain control they had received. Patients for elective surgery were provided with pain control information during their pre-assessments.
- Staff had access to dedicated pain team for advice and support as necessary.

Nutrition and hydration

- NICE guidelines were used as part of assessments tools to assess patients' needs. These included the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. This was used during patient's initial assessment in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- Records demonstrated that the Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. However, MUST scores were not always reviewed post operatively which may impact on a patient's recovery care and support people received.
- Food and fluids charts were not fully completed and contained large gaps in eight of ten records for those

who were at risk of malnutrition due to poor eating or drinking. Staff could not be assured patients were receiving adequate amounts of food and fluids in order to meet their needs.
- Patients had access to fluids and snacks in between meals. Patients who were at risk of malnutrition were assessed by dieticians and extra supplements prescribed as required.
- Wards had developed signs to identify patients who required assistance with food and fluids. These were not consistently used and these patients could not be easily identified by staff. We observed meal times on C and D levels. Patients received support with their meals and were encouraged to eat independently. However, patients did not always have their fluids at hand as their bedside tables were either too far away or not at the patient's level.
- There were no nutritional assistants on wards D3 and D4 due to staff vacancies. Nursing staff told us it was difficult to support patients fully at meal times and with dietary advice, as a result of these vacancies.
- The majority of patients said that they were offered choices and were able to choose from the menus. Comments included "very good food and plenty of it". Some patients had mixed comments regarding the quality and taste of the food. Patients commented it "all tasted the same", another patient felt it was better than they thought it would be.
- One ward kept a list of all ingredients used in meals prepared for patients. This enabled staff to offer advice to patients with specific dietary needs or food allergies and help them choose a meal which was suitable for their needs.

Patient outcomes

- The trust took part in a number of local and national audits. An audit relating to the use of preventative measures for the prevention of venous thromboembolism (VTE) was completed. The audit looked at 100 post-operative general surgical and orthopaedic patients. The sample consisted of elective and emergency patients.
- The result from the national hip fracture database (NHFD) hip fracture audit 2014, showed 87% of patients receiving surgery on the day or the day after their admission compared with England average of 73%. This was down from 2013 when the trust achieved 93%.
- The risk of readmission was above the England average for all elective surgery. The trust had set a target of 83 for 30 day readmission and between October 2014 and March 2015, this varied between 112-135 patients were readmitted.
- 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%.
- 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 once all treatment had been completed.

Competent staff

- The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules.
- Staff undertook role specific training to maintain and develop their skills. Advanced practitioners included a pain specialist to offer advice and support to patients and nurses.
- Staff were supported to undertake further training and development. The Urology department was nurse led. Nurse practitioners had completed training to undertake prostate biopsies, bladder scans and provided advice to patients.
- The General Medical Council (GMC) National Training Scheme Survey 2014 reported the trainee doctors within surgical specialities rated their overall satisfaction with training as similar to other trusts. Junior doctors told us that training was good and they had planned weekly training sessions.
- 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.
- Appraisal rates for the surgery division, at this hospital, for the period April 2014 to March 2015, varied by staff group and the team worked in. The average completion rate for appraisals was 73%. Two areas reported no staff had received an appraisal (AHP's in the pain unit and nursing and midwifery staff in the lymphoma team), whereas in 11 teams, 100% of staff had received an appraisal. Completion rates for medical staff, were 67% or above.
- 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.

Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical 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 including detailed handover.
- Patients' records showed they were referred, assessed and reviewed by multi-disciplinary team (MDT) such as dietitians, speech and language therapists and the pain management team as required.
- Pain specialist, and palliative care nurses were available and staff told us referrals were dealt with quickly.
- Medical support was accessed when required to support patients' medical needs.
- 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.
- Pharmacy support was available and served by 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.
- Physiotherapy and occupational therapy staff spoke to patients' GP, if they identified a patient who was going to need additional support once they had been discharged. They also worked closely with social services.

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. They followed an on call rota medical and nursing staff told us consultants were available for help and advice out of hours and weekends.
- 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.
- The pharmacy department was open seven days a week with limited opening hours at weekends. Staff had access to an on-call pharmacist for emergency drugs including weekends.
- 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.
- Nursing staff reported difficulties obtaining X-rays at weekends for orthopaedic patients who were one day post-surgery and needed an X-ray as part of their care pathway. This should have been booked as part of the admissions process, but this did not always occur.
- Access to the phlebotomy service was raised as a concern at weekends. Junior medical staff took bloods if a phlebotomist was not available

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 upon discharge. This detailed the reason for admission and any investigation results, treatment and discharge medication. Staff confirmed these were sent to GPs within 48 hours of their discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were followed to ensure decisions were made in the best interests of patients.
- The trust had introduced some new patient documentation and MCA assessments were completed in the booklets seen.
- We observed doctors visiting patients prior to surgery and giving explanations to patients prior to them signing consent forms.
- Patients told us clear explanations about their proposed surgery and procedures had been given to them. Staff had checked that they understood what they were consenting to. A patient commented "I think I know what's going to happen. I have signed the form and am happy".
  - Staff told us there was no one under a deprivation of liberty safeguard (DoLS) when we inspected surgical services. Two doctors were able to describe action they would take if patients did not have capacity to consent such as best interest decisions and involvement of relatives or friends as appropriate.

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.

Staff were caring and compassionate and treated patients with respect when providing care. Patients said staff were caring and responsive to their needs. Patients were encouraged to provide feedback on their care and this was analysed to improve the care provided. Patients were consulted and kept informed of their care and treatment. Staff sought consent prior to any procedure.

Compassionate care

- Patients were treated with compassion and care. We observed on several occasions on D4 staff treating patients who were confused and distressed with utmost care and respect.
- Patients were complimentary about their care. Comments included, "All the staff are brilliant", they commented that they were well looked after and that staff did their best in difficult circumstances.
- Staff were passionate and committed about the care and treatment they provided and we saw positive interactions with patients in all the hospitals we visited
- The Friend and Family test results from August2014 to March 2015 showed that 95-99% of patients would recommend the trust as a place to receive care and treatment which was better than the national average.
- The 2014 CQC Inpatient Survey found the trust scored similar to other trusts on all the key indicators.
- Patients were encouraged to provide feedback and this was analysed to improve the care provided. The Friends and Family Test results showed that patients were always given privacy when being examined.
- Patients on the surgical wards spoke positively about the care they had received. Staff were caring and dedicated, however, a number of patients did comment on the time taken for call bells to be responded to. They observed this was because the staff seemed very busy.
- Patients also commented that the wards could be noisy due to equipment alarms sounding and noise from other patients, some of whom tended to shout out. This made it difficult to sleep, particularly at night.

Understanding and involvement of patients and those close to them

- Patients and their relatives were positive about information they had received and said they felt involved in their care.
- Patients said they were able to speak with the consultant and other doctors caring for them and they involved their family, which they felt was important to them.

- They said nursing and medical staff provided them with clear information about the procedures and post-operative care. Where options had been available these had been discussed and patients had been able to ask questions to gain a better understanding.
- Pain control was also discussed including options such as epidural and other means of pain control.
- We spoke with three patients in the Eye Day Care Unit; none of them raised any concerns about their privacy or dignity not being respected. The patients reported all staff were very caring and kind. Staff were patient with them and took the time to listen to their concerns. We observed staff talking to patients in a gentle and considerate manner.
- Patients were given an explanation prior to the instillation of their pre-operative eye drops; however, the patient was not taken into a separate room to have the drops instilled to maintain confidentiality and privacy.

Emotional support

- Patients and relatives told us they received the support they needed to manage their treatment and hospital stay. A relative said the staff had been "extremely supportive" as they had difficulty coping when their relative was first admitted to hospital.
- Patients told us they had been reassured by doctors and they felt prepared for their surgery.
- There was a chaplaincy service available for people of all religious denominations to offer additional emotional and spiritual support to patients; staff were aware of the Church of England chaplain who visited regularly and available out of hours. Facilities at the trust included a Chapel, a multi- faith room. Senior staff said access and contacts were available with various local faith groups throughout the community and nationally.
- A counselling service was available to patients through referrals from consultants managing their care. 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 re-booked 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. The eye day care unit lounge did not have privacy curtains ; although they were treating mixed sex patients and this may have compromise patients' privacy.

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. Bariatric equipment could be accessed when necessary.

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.

Surgery

Service planning and delivery to meet the needs of local people

- The service had a day unit surgery which enabled people to have minor procedures without having overnight stays in hospital.
- On the day of their surgery, patients for elective (planned) surgery were admitted to the surgical admissions lounge. They were seen by the nurse and admitted for surgery and then post-operatively taken to the relevant ward.
- A surgical assessment unit had been recently introduced which meant patients were admitted to the appropriate area for their care, after an initial assessment on the unit for their immediate medical and care needs.
- Patients for rehabilitation were transferred between services and some patients were admitted to Andover hospitals which for some patients meant being close to home and their family.
- A review of the Ophthalmology and orthopaedic services was being undertaken by an external company to look at patient throughput and optimal utilisation of the service.

Access and flow

- The bed occupancy was significantly higher than the national average where the trust had an average of 88% occupancy over the past year compared to the recommended rate of 85%. Data and professional guidance shows that high occupancy was more likely to result in non-clinical transfers with its associated risks. On C and D levels, the occupancy between March and June 2015 was between 63 and 98%.
- 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 April 2014 – March 2015. The target was not being met in ophthalmology and orthopaedics.
- A review of the Ophthalmology and orthopaedic services was being undertaken by an external company to look at patient throughput and optimal utilisation of the service.
- Theatre utilisation (time theatre used for against the allocated session time) averaged 63% for the period February 2015 to April 2015 for ophthalmology, compared with an average of 75% for the hospital. The theatre in the Eye Day Care Unit was not used every week day, morning and afternoon.
- Nursing staff in the Eye Day Care Unit were undertaking some additional administrative duties due to staff sickness in the administration team. Staff reported there was a delay in the booking of operation dates due to staff shortages, adding to further delays experienced by patients.
- The Department of Health 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 trust's performance report between January and March 2015 showed that between 38 and 63 patient moves took place between 10pm and 7:59am at this hospital. Staff said this was due to the lack of available beds and acuity of patients.
- The discharge planning process commenced as soon as patients were admitted. Staff said this was easier for elective patients. Staff raised concerns around delayed transfers of care, particularly for trauma and orthopaedic patients. These patients were medically fit to be discharged, but were waiting for a package of care to be put in place by social services or waiting for a space to become available for rehabilitation in the community. Delayed discharge meetings took place twice a week, with social services and other services to develop action plans for patients. The community service was run by a different provider, staff reported this service was understaffed and prevented them from discharging patients sooner. Figures from the trust showed for this hospital there were 15, 17 and 19 delayed transfers of care for orthopaedics for May, June and July 205 respectively. This averaged around 10% of the total number of delayed transfers of care for the whole hospital.
- 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.
- The trust was one of only two hospitals that treated patients with Pseudomyxoma which was a rare form of cancer. They followed a detailed pathway and with a planned stay in hospital of three weeks.

Meeting people's individual needs

- There were appropriate arrangements in place with designated bays for male and female patients and facilities and senior staff said they adhered to their policy and there had been no same sex breaches.
- Access 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.
- Patient literature in the Eye Day Care Unit was only available in English. There was therefore a risk to patients whose first language was not English, as they may not fully understand their proposed treatment plan. No signs were seen advising patients how to access information in a different language or format, such as large print or easy read, nor, how to arrange an interpreter for their appointment. Staff we spoke with indicated there was a reliance on using family members to translate at appointments and during a stay in hospital.
- There were a variety of information pertaining to surgical procedures and maintaining healthy living and cessation of smoking.
- The trust has a process for staff to ask all patients over 75 years of age about dementia. This was part of the assessment of patients' mental and physical needs being considered and care plans initiated.
- 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.
- Patients had access to a dementia link nurse from the medical wards. 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 with dementia when they are in hospital. Carers were encouraged to stay on the ward outside the normal visiting hours.
- There were dementia champions on the wards we visited and the hospital used a sunflower symbol above a patient's bed to make staff aware of those patients living with dementia, to ensure the care and support was appropriate to the patient's additional needs. The hospital also had a number of dementia volunteers who spent time talking to patients on the ward.
- Patients with learning difficulty had access to a specialist link nurse. Staff told us they encouraged their carers to support these patients if possible. We did not see any information leaflets and consent forms in different formats such as easy-to-read.
- Staff said they did not know if there was a translation service, there was a risk of patients' surgery being cancelled due to lack of this facility. This information was not captured as part of the pre-assessment for elective (planned) surgery patients.
- The eye day care unit lounge contained chairs for patients to sit on whilst waiting for and recovering after their operation under local anaesthetic. No curtains were provided around each chair, so patient privacy was compromised. Confidential discussions with patients took place in a separate room. The layout of the lounge meant there was not enough space for a family member or carer to sit with the patient and offer support and reassurance. Theatre sessions were run as mixed-sex lists.

Learning from complaints and concerns

- 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 or matron.
- Patients said they were confident to raise their concerns and said they would speak to the ward sister or would tell their relatives.

Surgery

- All patients who raised a complaint received a written apology from the chief executive officer (CEO). Contacts information for the CEO was available on the trust's website to enable patients to raise their concerns.
- 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)'.
- The trust was monitoring their response to complaints within 25 working days. Data received from the trust showed for the months of January –March 2015, they were achieving between 37-56%.

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 all a local level. Staff felt supported by the multi-disciplinary team, joint working and strong clinical leadership. Staff were confident about working with Royal Hampshire County Hospital 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.

Patients' feedback was collected and used in the development of the service. The patient engagement initiatives such as 'through your eyes' listening event', 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

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. There was a strong emphasis on a consultant led- service, to achieve the best possible outcome for patients.

Vision and strategy for this service

- The vision for the surgical division was primarily focused around the trusts vision for a planned 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 patients' focussed to their 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.

Governance, risk management and quality measurement

- The trust undertook a number of audits in order to improve the outcome for the patients. There was a divisional risk register which clearly identified the risks within the department, such as patient flow and the implication on quality and finance.
- There was a clear governance structure and process in place within the surgery division. Governance meetings took place on a monthly basis, which included monthly morbidity and mortality (MM). Also reporting on finance and performance and quality issues within the division. They looked at serious incidents, cases of hospitals acquired infection, compliance with hand hygiene audits, performance against referral to treatment time targets (RTT). Once every two months staff took part in trauma audit meetings. Data showed high volume of patients were treated and low mortality rates.
- The data was captured on the divisional scorecard, which showed results for the previous 12 months so areas of improvement and decline could be easily seen and performance against the target set for each area. Review of governance minutes showed areas of concerns had been discussed and actions plans put in place.
- Clinical specialties reported to the divisional leads on a monthly basis, around key performance and quality indicators. The scorecard identified the top risks for that area and the mitigations which had been put in place, such as cancelled operations in orthopaedics due to bed availability managed by weekly admissions meetings and early identification and escalation of delayed discharges.
- In anaesthetics, there was a reduced number of trainee staff, resulting in inability to cover rotas, agency staff were used to cover any gaps and enable theatre sessions to run.
- Review of minutes from team meetings showed that learning from incidents was shared and performance in quality audits such as hand hygiene, cleaning of commodes and cannula care was discussed. There was no evidence to show that learning from clinical audits was shared, although these were undertaken.
- 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 director and operations director, with clinical directors for speciality.
- 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. However, there remained concerns that some issues were resolved in the short term, only for them to recur a few months later, such as difficulties around staffing. They acknowledged the recruitment of staff from overseas would resolve some of these concerns, once the new staff had been fully trained. Staff felt communication from senior managers could be improved.
- There had been a number of changes to staff in leadership roles at band seven and above during the last year. However, staff felt these changes had not impacted on the support they received and felt it was important to have a capable and competent leader in place.

Culture within the service

- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. Nursing staff told us their immediate manager operated an open door policy and worked on the ward as part of the team and very 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

- 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 June 2014 and June 2105, the average response rate was 37%, against a target of at least 30%. Participation levels were low on some wards and minutes were seen reminding staff of the importance of providing patients with a survey to complete.
- Healthwatch Hampshire had submitted a report to the trust on patient experiences for orthopaedic services. These were both positive and negative comments; gathered through a number of public engagement events. A written response from the trust included initiatives which had been introduced to improve patient care such as additional recruitment and the introduction of additional roles to support nursing care. Patients' feedback was shared with all staff for learning and development of the service.
- 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.
- A patient's experience questionnaire had been conducted this year, for the eye day care unit, which included questions about privacy. The results found that 90% of patients felt they were given enough privacy and dignity. Seventy seven percent of patients found it helpful being in the same room as patients who had already had surgery and 32% of patients would have preferred to have been in a separate recovery area after their operation. Patients overall were very happy with their treatment and the care they received.

Staff engagement

- The results of the 2014 trust staff survey were published on 25 February 2015. More staff contributed to the staff survey compared with the NHS average, with a 46% response rate compared with 42%.
- The trust's staff survey for 2014 had raised some issues in the surgical division, such as visibility of senior management, a higher level of reporting for bullying and harassment, but this was not being reported in line with trust policy. Other issues related to low staff morale and a possible reduction in incidents reporting for fear of getting blamed.
- The trust had been proactive in developing an action plan which included senior management to attend ward staff meetings to share information. The trust has launched 'Speak in Confidence' in April 2015, advertising the service in weekly communications and with a link on the intranet. They are planning to implement a multi-disciplinary "drop-in" sessions, at each of the hospital sites as part of face to face engagement with staff.
- A separate staff survey was planned for specific areas to look at local issues in more depth.
- Staff spoke positively about the strength of the teamwork, but felt staffing pressures impacted on the quality of care for patients.
- Staff reported through the 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 initiatives developed to improve the quality of service provision as part of the corporate plan. Clinical staff were committed in improving the outcome for patients with rare conditions including cancers.
- The trust is one of only two designated specialist treatment centres in the country for treatment of Pseudomyxoma. This is a very rare type of cancer that usually begins in the appendix, or in other parts of the bowel, the ovary or bladder. The hospital has treated more than 1000 such cases. The diverse multidisciplinary team has developed the skills to help patients through this extensive treatment, and share their knowledge on international courses and conferences.

Surgery

- Surgeons at the trust performed a higher than average number of oncoplastic (breast conserving surgery) to ensure good clinical margins, without compromising on aesthetic outcome.
- 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 at the trust have changed practice world-wide, such as new techniques for the biopsy on operable tumours and benefits of waiting six weeks after completing chemotherapy before performing liver resection.
- There were regular opportunities for staff to undertake secondments within the division to develop their clinical and leadership skills.
- 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.
- An efficiency review had been undertaken by an external provider of the orthopaedics and ophthalmology services.
- 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

Intensive Care services at Basingstoke and North Hampshire Hospital (BNHH) consisted of an Intensive Care Unit (ICU) and High Dependency Unit (HDU), both of which had eight beds. Patients requiring level 3 care were treated on ICU and patients requiring level 2 care were treated on ICU or HDU. 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. There is also a Critical Care Outreach Service provided at BNHH that provides an outreach service for patients in the hospital and a follow up service for patients once they have been discharged from hospital.

The management of critical care services for the Trust covers both the ICU and HDU and BNHH and the ICU at Royal Hampshire County Hospital (RHCH). 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.

During the inspection of Critical Care Services we visited ICU and HDU. We spoke with eight patients, four relatives and 25 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 eight 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. 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. 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.

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

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

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 BHNN and at RHCH.

Infection control practices were followed. There were low numbers of unit acquired infections.

The environment and equipment were well maintained and stored securely.

There was effective management of medicines, prescribing was electronic. Medicines were stored in secure areas. Medicine preparation rooms were secure, with members of the public not being able to access the rooms. 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.

There was a critical care outreach team to respond to requests to assess deteriorating patients in the general hospital. However, this was not available at night. Overnight a night practitioner had a dual role for providing an outreach service and managing beds across the hospital.

Staffing levels met patient's' needs. Both nursing and medical staff levels were in line with relevant national guidance. 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.

Incidents

- All staff in the critical care units 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 acknowledged.
- 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 32 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 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 and were encouraged to present case studies. 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 there had been two incidents of unit acquired pressure ulcers and no incidents of catheter related urinary tract infection, VTEs or falls.

Cleanliness, infection control and hygiene

- 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 2013 to March 2015 there had been one unit acquired MRSA, which occurred during the period January to March 2015. This one unit acquired MRSA infection was localised and not present in the patient's blood. 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 units were 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.
- 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.
- Both ICU and HDU had side rooms to treat patients who had infections and reduce the risk of cross infection.
- Hand cleaning facilities, including hand gels were available at the entrance to the unit and throughout the unit. Patients said staff always washed their hands before and after providing care and treatment.
- 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.
- Following the trust's policy, all patients were screened for MRSA on admission to the unit, treated prophylactically and rescreened five days later.
- There was a unit infection control team that included medical and nursing staff, to support staff with infection control practice.
- It was observed during the inspection that engineers were running the water from the water taps to reduce risk of water borne infections, such as legionella.
- 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 and we observed this happening in practice.
- 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 control and prevention audits assessed compliance with policies for hand hygiene, insertion of venous cannulas and urinary catheters and the ongoing care of venous cannulas and urinary catheters. Where the unit did not score 100% compliance the reason way and action taken were recorded. For July 2015 critical care services at BNHH scored 100% in all areas.
- Comprehensive annual infection control and 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 to both ICU and HDU units 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 both units. Records showed the resuscitation equipment should be checked daily. Records documented the emergency equipment was checked daily. A tagging system, where the tags had to be broken to access equipment on the trolley, reduced risks of equipment being taken from the trolley and not being replaced.

- There was a transfer trolley in both units 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 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, haemofiltration 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, which included intravenous fluids, were stored in secure areas. Medicine preparation rooms were secure, with members of the public not being able to access the rooms. Medicine fridges were kept within cold storage limits and a register of these were kept daily.
- Nursing staff said they received training about the safe administration of medicines and could only administer medicines after they had completed competency assessments.
- 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 history of patient care and treatment. The majority of patient records were paper records. 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.

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.
- Staff told us they had completed training about safeguarding adults and children.
- 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.

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 infection control which was at 76%. Medical staff only achieved the 80% compliance with conflict resolution, counter-fraud, health and safety, and safeguarding adults and children.
- All staff confirmed they had time provided for 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 the outreach team. The outreach team consisted of six outreach nurses and one part time physiotherapist and provided a service seven days a week during the day. There was no outreach service at night. This meant the service 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".
- At night the outreach service was provided by a night practitioner. The outreach team said the night practitioner's role mainly involved bed management concerns. Whilst the clinical knowledge contributed to this role there was concern about the lack of formal outreach service at night for deteriorating patients. There was no data that demonstrated this had resulted in harm to patients, but to reduce risks the outreach team said that ideally they would like the service to be provided at night as well as during the day.
- The outreach team provided support to staff on general wards by assessing their skills with observations, documentation and how to communicate essential information with regard to a deteriorating patient. They provided training at staff induction about the EWS and the role of the outreach team.
- Risk assessments were completed for patients in all the critical care areas. These included assessments for the risk of developing pressure ulcers, venous thrombo-embolism, malnutrition and falls. When a risk was identified, the action required to reduce or manage it was detailed.

Nursing staffing

- Staff reported that following the merger of BNHH and RHCH hospitals a number of nursing staff had left, which had made achieving required staffing levels difficult. However they reported that the situation had significantly improved, with ongoing recruitment and development of staff. This meant 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. A member of the senior nursing team from RHCH was working along staff at BNHH to support the significant junior nursing team with management and critical care skills. Staff said had found this invaluable.
- Staff worked across both ICU and HDU, with one member of staff being in overall charge of the shift for ICU and HDU. Staff were allocated daily whether to work in ICU or HDU, with an emphasis being placed on ensuring continuity of care for patients. This meant staff generally worked a stretch of shifts on ICU or HDU, rather than being moved from one area to the other on a daily basis. 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 from RHCH. 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.
- In June 2015 nurse vacancy rates for the unit were 15% with a staff turnover of 16%. Staff sickness was at 5%.
- 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 met the standard of having one clinical coordinator in charge of the shift.
- When the unit was quiet staff 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.

Medical staffing

- Medical staffing on the critical care units 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.
- Recruitments 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 middle grade 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.

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. 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 across both sites. 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.

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.
- 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 14. Some of the audits identified did not show completion dates as expected. There was, however, evidence that learning form clinical audits were 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 BNNH included an audit of the NICE GS83 (rehabilitation after critical illness). An initial audit had been completed followed by a re audit to measure improvements in relation to rehabilitation.

Pain relief

- Patients' pain and response to pain relief were monitored 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.
- Speech and language therapists were available to check that patients were safe to swallow, and to offer advice accordingly. 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 monitored on patient's daily charts aided clinical decision making with regard to patient's goals for fluid and nutritional intake.

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 1 January 2015 to 31 March 2015.
- The data showed that mortality rates were similar to those of comparable critical care units with the exception of patents admitted with pneumonia, where the mortality rates were greater than those of similar units.
- Data for unplanned readmission to the unit within 48 hours showed the unit was performing at a similar rate to other similar critical care units.
- ICNARC data showed the MRSA, and blood borne infections were similar to those of comparable units. For the period April 2013 to March 2015 there had been one unit acquired MRSA, which occurred during the period January to March 2015.
- The same data collection showed the unit had more delayed discharges (discharges from the unit over four hours after the decision was made to discharge the patient), more out of hours discharges (discharges from the unit between the hours of 10pm and 7am) than other comparable units. The unit's quality dashboard for June 2015 showed there had been 23 delayed discharges, with 16 of them delayed over 12 hours and one out of hours discharge for that month.

Critical care

Competent staff

- 61 % 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.
- The nurse educators post was vacant. Recruitment processes were taking place to appoint a nurse educator. The nurse educator at RHCH supported nursing staff at both BHNN and RHCH until a nurse educator was recruited for BNHH. Staff spoke positively about the support and training opportunities provided by the nurse educator.
- 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 77% for unit staff and 100% for the outreach team. 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.
- 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 2015 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 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 BNHH. If a child was treated on the critical care unit at BNHH a children's nurse would assist the critical care nursing team in the care and support of the child and their family members.
- Once discharged to the wards patients were followed up by the outreach team to monitor their progress and to support the ward staff who were looking after these patients. However, this service was only available during day hours, and so 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.
- There was a multidisciplinary handover every morning, so all staff had an awareness of the needs of all patients.

Seven-day services

- The service had consultant intensivist cover 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.
- The outreach team was only available during day hours seven days a week. This meant this service was only available during day hours, and so 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."

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,
- 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, and records were kept of these meetings.
- All staff from ICU and HDU had a handover together in the morning that discussed the needs of all the critical care patients.

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 2008. 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.
- Side rooms on the HDU had CCTV coverage. Staff said this was to ensure patients in side rooms were monitored and observed. They said the CCTV was switched off when personal care was being delivered. Patients and their representatives were informed of the use and reason for the CCTV cameras and records kept of the discussions. However, there was no process for obtaining consent from patients or making best interest decisions about the use of CCTV cameras.

Critical care

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. Patient told us examples 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 patients and their relatives. For example, they would check if they wanted to be contacted at night and they spoke with patients to explain their care whether they were conscious or not.

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 a formal follow up service for patients to discuss their experience in ICU and how it physically and psychologically affected them. This aiding the emotional recovery of patients.

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.
- All the patients we spoke with were highly complimentary about the care and support they received. They were also positive about the staff approach to promoting their dignity. For example, one patient called the inspection team over because they "had to tell about the personalised expert care" they had received. Another patient commented that the nurses were very caring and were sensitive to their needs.
- A patient with their relative said they felt the doctors and nurses provided excellent and personalised their care.
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.

Understanding and involvement of patients and those close to them

- Patients and their relatives/ representatives were active partners in their care. Staff were fully committed to working in partnership with patients and their relatives/ representatives. Patients, who we were able to have conversations with, felt they were well informed and involved in the decision making process regarding their treatment.
- Relatives said they were fully informed about their family member's treatment and care. 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.
- All patients and their relatives we spoke with said information was discussed in a manner they understood. They said there was always a member of staff available to help them understand the explanations.
- 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
- There was an ethos of involving the patient at all times and consideration of the emotional stress being treated in in a critical care unit would have on the patient. To reduce anxiety and stress, treatment and care was explained to patients at all times whether they were conscious or unconscious, Relatives said staff explained

everything to the patient, even though their understanding might be limited or not known, We observed staff explaining to patients what care was being delivered. This happened for patients who were awake and for patients who were sedated and ventilated.
- Relatives said medical staff involved them in discussions and decision making about their family members care and treatment. They felt very involved in their family members care.
- 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.

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 relative available during the breaking of news to provide emotional support.
- 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 for their relatives.
- The outreach team at BNHH offered a follow up clinic to all patients who were treated on ICU and HDU for over 72 hours. This gave patients the opportunity to have their stay and care in ICU or HDU explained to them to aid them with their emotional recovery.

Are critical care services responsive?

Good

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

We rated responsive as 'good'

Critical care services were responsive to the individual needs of their patients. Staff made reasonable adjustments, such as enabling parents and/or carers to stay and be involved in care for patients with a learning 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 24-hour 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' ongoing treatment and emotional and psychological support. These were provided at BNHH.

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

- The critical care units consisted of an intensive care unit and a high dependency unit. ICU provided level 3 and some level 2 care, whilst the HDU provided level 2 care and treatment. They provided a service for general surgical and medical conditions as well as for specialist gastro intestinal cancer surgery. There was a plan to increase the number of specialist gastro intestinal surgery carried out to meet the needs of the national population.
- The HDU and ICU, prior to the merge of the two hospitals had been managed by different departments. The management of both services had changed to be managed by the critical care services, in order to provide a seamless and comparable service for the local population.

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.
- Information about the critical care services was available on the trust website. There was general information that was relevant for both BNHH and RHCH and specific information about the unit at BNHH. 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.
- Information was available on the units to support staff in caring for patients who had a learning disability or who were living with dementia. Staff knew there were specialist nurses for both learning disability and dementia and knew they could access the contact details through information files on the unit, the trust intranet or from the hospital switchboard. Staff spoke about reasonable adjustments they could make if patients with a learning disability or living with dementia were admitted to critical are services. This included making provision for relatives or carers to stay to support the person with their care.
- There were multiple large clocks throughout the units to help orientate patients to the time of day. White boards displayed information such as the day, season and the weather to help orientate patients who were confused.

Access and flow

- ICNARC data covered both ICU and HDU. This detailed bed occupancy across ICU and HDU was similar to that of other comparable critical care units.
- ICNARC data showed discharges occurring out of hours (between 10pm and 7am) were greater (worse) 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 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 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 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 hemofiltration. Processes were in place and followed to ensure patients were discharged home safely with the appropriate support and follow up.

Critical care

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.

We rated well-led as 'good'

Staff were aware of the vision to combine the critical care units from BHNN and RHCH 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 BNHH and RHCH, with the same policies and procedures, training, equipment and staff working across both sites.

Governance processes 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 BNHH. Within the service there was a culture of support and respect for each other, with staff willing to help the critical care unit at RHCH 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.
- The philosophy for the critical care unit was displayed on the unit's website. This detailed, "Our team is dedicated to the provision of high quality, innovative and responsive care to our patient, their families and significant others. We value and respect equality and diversity whilst striving to deliver individualised patient care. We aim to foster a positive learning environment to ensure our team are committed to achieving clinical excellence."
- Staff were aware of the vision to combine the critical care units from BNHH and RHCH 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 BNHH and RHCH 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 discussion 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 was a separate register for the critical care units. The risk register for BNHH had 12 risks identified. The risk covered, for example, pharmacy input to reduce errors, staffing and skill mix and delayed discharges. 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 BNHH 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 from 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 BNHH. 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.
- Medical staff said they were very well supported by consultants and had not "felt clinically out of their depth." All staff said working on the unit was a positive team experience and they felt well supported by all staff.
- 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.
- 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.
- Discussions with members of staff demonstrated the department was developing a culture of wanting to be open and ready for change.

Public engagement

- Patient and family feedback was obtained by the use of satisfaction surveys, as well as during follow up clinics once a patient had been discharged from hospital

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.
- 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, in collaboration with Southampton University, 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.
- The unit was working to a Cost Improvement Plan to endure sustainability that covered critical care services across both BNHH and RHCH. 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 plan was monitored monthly.
- A junior doctor described how they had designed a new fluid record chart which was now used throughout the trust.
- Surgical fellows were used innovatively on the HDU to maintain safe levels of junior doctors.
- Senior nurses and two of the senior medical staff were active members of the Wessex Critical Care Network. This enabled them to share improvements and innovations to develop critical care services.

Maternity and gynaecology

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

Information about the service

Basingstoke and North Hampshire Hospital is part of the Hampshire Hospitals NHS Foundation Trust. The hospital provides maternity and gynaecological services to the community of Basingstoke and the northern areas of the county of Hampshire. Between April 2014 to April 2015 there were 2,837 births at Basingstoke and North Hampshire hospital.

Obstetrician and midwife led services are provided for early pregnancy, ante-natal, induction of labour, labour and post-natal care. There is an antenatal clinic, early pregnancy assessment unit and Maternity Day Assessment Unit. The early pregnancy assessment unit has five day case beds for women who require surgical or medical treatment for miscarriage. Gynaecological patients can also be admitted to the unit for treatment or investigations. Inpatient maternity care is provided on a nine bedded ante-natal ward, the delivery suite contains six 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 18 bedded post-natal ward.

The gynaecology service is provided on a 10 bedded women's health 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 10 patients and 30 staff, these included midwives, nurses, housekeeping staff, senior managers and doctors. We observed a shift handover and held focus groups attended by a further seven staff. We reviewed seven patients' healthcare records. Before, during and after our inspection we reviewed the trusts performance information.

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

Maternity and gynaecology

Summary of findings

Maternity and gynaecological services were safe, effective, caring, responsive and well led.

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. There had been one Never event (a serious, largely preventable patient safety incident which should not occur if the available preventative measures had been implemented) in the maternity service in May 2015. We saw information to support the reason for the never event had been comprehensively investigated and systems were in place to minimise the risk of recurrence

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

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 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 RCOG, Safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. The guidelines had been unified across the trust to ensure all services worked to the same guidelines.

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

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

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. There had been one never event in the Maternity service (a serious, largely preventable patient safety incident which should not occur if the available preventative measures had been implemented). The never event had occurred in May 2015. We saw information to support the reason for the never event had been comprehensively investigated,

and systems were in place to minimise the risk of recurrence.

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.

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, however there had been occasions during April 2014 to March 2015 when the rate had been 1: 1:32-37 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. This included a comprehensive assessment of the staffing needed to provide the care required by a woman in the maternity services.

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.

Records were not consistently stored securely to prevent unauthorised access on the gynaecological ward.

Incidents

- There had been one Never Event in the Maternity service between May 2014 to May 2015. A never event is a serious, largely preventable patient safety incident which should not occur if the available preventative measures had been implemented. The Never Event had occurred in May 2015.
- Senior medical and midwifery staff had investigated the reasons why the Never Event had occurred and shared the results of the investigations via email and in team meetings with all members of staff. Midwives told us that lessons had been learnt and it was evident from information seen, that documentation and further checks had been devised to minimise the risk of the Never Event recurring. Midwives told us that as a result of the Never Event women wore further identification in the form of wrist bands to alert staff to the type of post-operative care required. The trust had asked the Royal College of Gynaecologists to visit the hospital and review the investigation to ensure robust systems were in place.
- All grades of staff we spoke with were aware of the electronic incident reporting 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. We spoke with three domestic and housekeeping staff that did not have access to the system. They were clear on 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.
- Reported incidents and subsequent investigations were presented at regular risk meetings. Midwives told us this was to ensure learning was shared.
- All reported incidents across the service trust wide were discussed at the monthly performance meeting. Also discussed were high level risks and patient safety issues such as cardiotocograph (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 were held to discuss trust wide concerns. Incident reports for the previous 24 hours were discussed and actions planned for further investigation.
- Hospital trusts have a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm; this is known as Duty of Candour. All grades of staff we spoke with were aware of the principles of Duty of Candour. Staff explained how women were informed about investigations into any incidents which related to the care they had received. We were told by senior nurses that there had been no trust wide training, however the incident reporting system contained a section on openness to remind staff of their responsibilities

Safety thermometer

- 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 on the ward. It is considered to be best practice to display the results of the Safety Thermometer audits which allows 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. For example they monitored major obstetric haemorrhage, fresh eyes audit (an audit to assess if CTG results had been checked by a second midwife) and maternal admissions to the intensive care

unit (ICU). This information was recorded on the maternity dashboard and was available to maternity staff via the intranet. This information was not displayed in the unit.

- Patient safety maternity indicators demonstrated that the numbers of major obstetric haemorrhage, admissions to ICU, VTE events, meconium aspiration, babies admitted to the neonatal unit unexpectedly were within the local and national benchmark. The number of 3rd and 4th degree tears, VTE assessments, neonatal morbidity - readmissions to postnatal ward was above local and national benchmarks (April 2014 – March 2015).

Cleanliness, infection control and hygiene

- All clinical areas were visibly clean. Staff were seen cleaning equipment after use. "I am clean" stickers were not consistently used on all equipment used to deliver or monitor care. On the gynaecology ward, green tape was used on commodes to indicate they had been cleaned and were available to be used. The trust infection control policy did not dictate that the green "I am clean" stickers were to be used on shared equipment such as hoists and drip stands used in the clinical area and this was confirmed by a specialist infection control nurse. Ward staff told us they always cleaned the shared equipment after use; however there was no system in place to assure staff that equipment had been cleaned to prevent the spread of hospital acquired infections.
- We saw staff adhering 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.
- Regular hygiene and infection control audits were completed and learning and actions demonstrated. Monthly infection control audits were conducted across the maternity service. The audits looked at a variety of infection control measurements such as hand washing, catheter insertion and commodes. We saw the delivery suite had consistently been awarded 100% with the exception of April 2015 when the suite was awarded 90% when incorrect hand hygiene processes were observed.
- 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.
- 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.
- In both the gynaecological ward and maternity services we saw cleaning check lists displayed outside patients 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. One member of this team told us "I love this ward; I like to make sure it is very clean for the patients". We saw 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.

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 we saw the baby resuscitaires had lists attached to them to ensure the equipment had been checked on a daily basis and 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 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, such as slings, were available to evacuate a woman from the birthing pool in the event of a collapse.
- Within the gynaecological ward, equipment used to support the delivery of care for example hoists and portable monitoring equipment was stored appropriately. All equipment displayed service information. We noted that all equipment had been checked within the last twelve months.
- Other equipment was available in the maternity services. For example fetal cardiotocograph (CTG) equipment and ultrasound equipment were available. We noted stickers were attached to show the equipment had been serviced and checked. All of the Midwives we spoke with told us they had enough equipment to enable them to care for women safely.
- The early pregnancy advice centre contained a consulting room and a five bedded day ward for women who required treatment.
- One room used for patient assessment in the Maternity Assessment Unit (MAU) was small with no sink and no computer link. One midwife told us they were unable to conduct the same level of assessment as in other rooms because they could not access the computerised assessment of CTG.
- Doors in to the maternity unit were locked. Entry into the unit was via a buzzer system. In order to leave the unit visitors and staff had to push a door release button. There were cameras situated at the door entry, and screens at the main desk which enabled staff to monitor who entered and exited the building.
- There were two dedicated obstetric theatres. One was for elective caesarean sections and the other for unplanned caesarean sections and obstetric emergencies.

Medicines

- Medication was stored correctly within locked cupboards and resuscitation trolleys.
- There was a portable medicine trolley on the gynaecology ward**.** This was locked and chained to the ward for security. The trolley contained hospital prescribed medication and medication patients had bought with them on admission to the ward. We noted a significant amount of single strips of medication stored in the trolley. These strips were not allocated to individual patients. The senior member of staff on duty told us this medication had been kept in case patients may have been prescribed the medicine and there was a delay in dispensing from pharmacy. It was difficult to determine the expiry date on the strips of medication. Patients may have been at risk of receiving medication that may have expired. We discussed this with the senior member of staff and when we returned to the ward the medication strips had been removed.
- 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.

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 the gynaecological 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. We saw that assessments had been completed. However, further plans to support any identified risk had not been fully documented. Staff were fully aware of the risks to patients and this had been documented in their handover documentation. The senior member of staff on the ward told us further training was planned to ensure all staff were competent to complete the assessments.
- Records in the gynaecology ward were not consistently stored securely. The records trolley was stored in a room which was staffed for most of the day. However, the room was unable to be locked to prevent unauthorised access when the room was unoccupied. The senior nurse for the service told us they were waiting for funds to enable them to purchase a suitable lock for the room.
- 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 concerns regarding the consistency of interpretation of fetal heart traces.

- 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 fax 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.
- Checklists were in place in patient's notes which ensured 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". They told us that the care and treatment provided was "good". One patient on the gynaecology ward told us "they are so kind and there are no bossy ones".
- 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, for example in record keeping and discharge arrangements. There were also areas for further improvement, including documenting parenting capacity in records. An action plan and further recommendations were developed with deadlines for completion.
- Mandatory safeguarding training updates had not been completed by all maternity and gynaecology staff. The trust target for attendance was 80%, we saw that 74.66% of staff had attended safeguarding adults' updates and 74.66% had attended safeguarding children updates.
- Sufficient medical staff had not attended safeguarding training updates to ensure they were up to date with their knowledge The trust target was 80%, we saw that 42.86% of doctors had attended safeguarding adults training and 42.86% had attended safeguarding children training.

Mandatory training

- Compliance with statutory training was not fully met. The trust target for attendance for updates for mandatory training was between 80-95% dependant on the subject. Subjects included basic life support, equality and diversity, manual handling and infection control. For example the trust target for attendance at infection control training updates was 80% we saw that 45.89% of nurses and midwives and 42.86% of doctors had attended the training. The trust target for manual handling updates was 80% and we saw that 67.12% of nurses and midwives and 35.71% of doctors had attended the training. There was a risk that sufficient staff had not attended a range of courses to update their knowledge to enable them to deliver up to date safe care. From information sent to us by the trust, we read that there has been an increase in the amount of training places available. The extra training places were to be held at a variety of locations and times to ensure staff were able to attend training updates.
- Midwives and obstetricians undertook further role specific skills and drills prompt training practical emergency obstetric training (PROMPT) neonatal life support and fetal monitoring.

Maternity and gynaecology

Assessing and responding to patient risk

- Risk assessments were completed on the initial maternity booking and continually evaluated throughout the woman's pregnancy. All patients were assessed for the risk of venous thromboembolism (VTE). 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 target had been achieved.
- Midwifery staff completed the modified early obstetric warning score (MEOWS) to assess women's observations. This system enabled midwives to record observations and gave protocols for staff to follow if the observations deviated from the woman's norm.
- Women who required high dependency care were cared for in a three bedded observation bay on the post-natal ward which was staffed by a midwife from the labour ward. Midwives reported they had good support from the intensive care outreach team.
- 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 had achieved 97% completion of the fresh eyes audit. 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 the gynaecology ward. The scoring system enabled nurses to assess patient's physiological observations such as temperature, pulse and blood pressure. Protocols were provided 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 and nurse staffing

- Records demonstrated that staffing levels were assessed three times a day on the gynaecological ward. The nurse in charge used the Safer Nursing Care tool (an assessment tool to ensure the ward had the right staff, with the right skills in the right place) to ensure the ward was staffed appropriately.
- The gynaecology ward had 10 inpatient beds and aimed to have a ratio of one trained nurse to five patients, plus one health care assistant (HCA) during the week day and two trained nurses overnight. The amount of inpatients on the ward at weekend varied, however staff told us there was usually very few (between, on average two to four) patients. Additionally the ward sister worked two supervisory days and one clinical day.
- All grades of nursing staff on the gynaecology ward we spoke with felt there were times when there were not enough staff to provide care. The staff told us they were working longer hours to cover shifts appropriately.
- Nursing ratios (the ratio of trained nurses to patients) was assessed weekly to ensure enough trained nurses were on duty. Senior staff told us any shortfall in staffing was usually covered by ward staff or the ward sister worked clinically on their supervisory days. The senior staff on duty told us there had been an increase in the sickness rate during July and this had impacted on the ward staffing establishment. We reviewed the staffing rotas and saw on 13, 15, and 19 July trained nurses had not been able to take one of their breaks because of staff shortages. The maternity ward was joined to the gynaecology ward and nurses told us that the midwives were supportive and flexible and provided cover for clinical need if required. On 19 July there had been one trained nurse on duty, with one HCA in the afternoon. There were two patients on the ward during this time. The ward staff had raised concerns to senior hospital management because the ward was open to emergencies over the weekend period, and they were concerned they did not have enough staff to cover for a potential emergency. Ward staff completed incident reports when they felt there were not enough staff to

care for patients. We reviewed the incident reports and although low staffing levels had been reported there was no documentation to support there had been an impact on the delivery of safe patient care.

- We spoke with five patients on the gynaecology ward. They told us they felt there were enough staff on the ward to care for them in a timely manner.
- Midwives of all grades told us there were times when they were very busy and felt as if they did not have enough staff. Senior managers told us they had a vacancy of 1.2 whole time equivalent (WTE) across the whole of the service. However, they currently had 10 WTE bank staff which covered maternity leave and sickness absences across the service. The funded midwife to birth ratio was on average 1:30 which met the trust national and local benchmark. However, there were times when the midwife to birth ratio was 1:32-34.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. One senior nurse told us "there are definitely times when there are not enough midwives to look after the women".
- 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 (for example the risk midwives) in clinical areas and the ongoing 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 give 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. Midwives told us they were able to access further support from other maternity services within the trust if 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% 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. The handover was well attended, by midwives, specialist doctors, clinical manager, consultant anaesthetist, associate specialist anaesthetist, anaesthetic nurse, ODP (operating department practitioner) scrub, midwife for risk consultant and the Consultant Obstetric and Gynaecologist for the day. The staff reported on expected births and on-going home births. Ante natal patients and staffing levels were also discussed. All the cases discussed were listed and kept as a record of the handover. Doctors also had written information to take away with them to act as an aide memoire.

Medical staffing

- The trust had devised a system to ensure sufficient senior doctors were consistently available. Some specialist registrar doctors were, similar in position to that of a 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 130 hours a week of consultant cover**.** The Consultant presence consisted of seven non –resident consultants, two substantive resident consultants and three locum resident consultants, who were due to become substantive in the near future.

- During the daytime consultants were not roistered to do other clinical sessions during labour ward cover. This was to ensure they were available at all times.
- A separate theatre team for the obstetric theatre was available all day. This was to ensure women who required a caesarean section had prompt access to surgical intervention if required.
- 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 on the gynaecology ward had recently received Major Incident training. The information was displayed in the staff rest room to ensure everyone was aware of their roles and responsibilities.

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. These 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.

Patients 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 was delivered in line with 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 figures for April 2014 to March 2015 showed that 63% of women had a normal delivery which exceeded the national figure of 60%. The hospital elective caesarean section rate for April 2014 to March 2015 was 13% which was higher than the England average of 10.9%. All grades of midwives told us they actively promoted the benefits of natural childbirth 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 date's' babies

(unborn babies whose size was not commensurate with their due date). The unit was using the new charts and there was an ongoing audit to check whether the charts were effective. The audit programme was a joint programme with Royal Hampshire County 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.
- A pelvic floor research trial co-ordinator was employed within the gynaecology service. Their role was to co-ordinate the trust participation in national trials that measure and monitor the care and support given to women with uro-gynaecological concerns.

Pain relief

- Patients in the gynaecology ward reported that they received pain relief in a timely manner. One patient told us "if I need something for pain they always give it to me very quickly". Patients in the Gynaecology 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 consultant anaesthetist told us that within the last year (January to July 2015) no-one had to wait longer than an hour to receive an epidural. The hospital episode statistics (HES) maternity statistics for 2013/2014 showed the England average for woman 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

- All of the patients on the gynaecology ward told us the food was good. One person told us "there is a good choice and you get what you ask for". 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.
- Ward staff told us they had access to a variety of menu choices to enable them to meet patient's cultural and religious requirements.
- 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 four times. For the remaining eight months the trust fell slightly below target with between 78% and 79.8% of women who initiated breastfeeding.

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 of local and national targets. We reviewed the dashboard for April 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 figures for April 2014 to March 2015 showed that 63% of women had a normal delivery which exceeded the national figure of 60%.
- The hospital elective caesarean section rate for April 2014 to March 2015 was 13% which was higher than the England average of 10.9%. Ventouse delivery was 4% which was below the benchmark of 7%; forceps delivery

was 7% below the benchmark of 8%. All grades of midwives told us they actively promoted the benefits of natural childbirth 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 the gynaecology ward 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 consultant anaesthetist to determine women's experiences after receiving an epidural anaesthetic. A form was given to women to complete prior to discharge home. The form gave women the opportunity to feed back on their experience and discuss any residual symptoms with the anaesthetist

Competent staff

- Staff across both services had the necessary skills and experience to provide effective care and treatment.
- Patients on the gynaecology ward told us they felt well looked after and the staff "knew what they were doing".
- Senior staff on the ward had organised a competency day to ensure all staff were competent and had the necessary skills to care for the patients on the ward. The training included insertion and removal of catheters, electrocardiogram (ECG) recording and removal of vaginal packs. The course was delivered on a Saturday to ensure most staff were able to attend. We saw from records that most staff had attended and further courses were planned for staff that was unable to attend on the day.
- 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%. For April 2014 to April 2015, 54% of nursing and midwifery staff band 7 and above and 64% of other clinical staff including healthcare and maternity assistants had 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).
- 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 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.
- 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 (midwife managers, clinical governance and risk 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 for example, doctors, midwives, anaesthetists and theatre staff. This promoted effective communication and gave the opportunity for shared decision making.
- Midwives reported good support from the intensive care outreach team and staff from the neonatal unit.
- One consultant told us "we excel at the relationship between midwives and consultants".
- 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

- Senior staff on the gynaecological ward told us they were able to access an out of hour's medical cupboard which contained various medications such as antibiotics if women required them.
- Radiology, MRI and gynaecology scanning were available at weekends and out of hours if required.
- 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.
- Haematology services were available out of hours. This was to ensure urgent blood samples were analysed and blood products were available should a maternal haemorrhage occur.
- Consultants were present during weekends on the maternity unit. They were available for advice and support during the night.
- The maternity assessment unit was open on Saturday and Sunday from 10am to 4pm.
- 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 the maternity unit if further investigations were required.

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 that 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 told us on the gynaecological ward that 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 fax if women were requested to attend for further investigation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients on the gynaecology ward told us they were asked for their consent prior to any medical intervention. One woman told us "they explained everything to me, gave me time to ask questions and then I signed a form to say I gave my permission".
- On admission to the gynaecology unit women were screened to assess whether they would require a

Deprivation of Liberty Safeguard (DoLS). This was included as part of the nursing assessment. 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.

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 a bereavement. There were also specialist support and counselling services available.

Compassionate care

- Patients on the gynaecology unit told us staff were kind. One patient told us "they are lovely here". We saw positive feedback displayed on the boards in the ward. One patient had written "I have been extremely well looked after and made to feel very at ease at a worrying time. Thank you".
- We observed throughout our visit that women were treated with respect and dignity. Curtains were drawn around patients on the gynaecology 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 ward displayed their Friends and Family test results. For June 39.6% of patients responded and 98% of the responses said they would recommend the ward. All of the patients we spoke with told us they would recommend the ward to their relatives and friends.
- The trust participated in the Friends and Family test. The response to the Friends and Family test trust wide 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?'

Understanding and involvement of patients and those close to them

- Patients on the gynaecological ward 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 medical 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) to provide support to women and their families. 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 at their homes, their GP practice or the Maternity Centre at Andover War Memorial Hospital.

Care and treatment was co-ordinated with other services and other providers.

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) of 18 weeks set by the Department of Health was met.

The needs of women are taken into account when planning and delivering services.

Complaints and concerns are always 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. This included at their homes, GP practice or Maternity Centre at Andover War Memorial Hospital. Women told us they were able to choose where they would like to have their ante-natal care. Women with more complex health needs attended multi-disciplinary clinics held at the hospital.
- The consultant anaesthetist ran an 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 the gynaecology ward told us they rarely had medical and surgical outliers, (patients on their ward from another medical or surgical speciality). This meant they did not have to cancel patients because of the lack of gynaecological beds.
- 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 ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners if

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

- Systems were in place to review service plans to meet the needs of local people. 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 from women about the current services on offer.

Access and flow

- The maternity assessment unit was open Monday to Friday 8am to 8pm. The unit was staffed by midwives and a consultant was available on most days. Midwives told us if a consultant was not present on the unit they were contactable by phone. There were four midwife sonographers who were able to use ultrasound equipment. Community midwives were able to directly refer women to the unit to have scans which checked for growth or presentation. 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 unit via their G.P, practice nurse or midwife. The unit offered both a nurse led and consultant led clinic which enabled women to have prompt access to any early pregnancy related problems. The unit offered 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 including the use of Methotrexate for ectopic pregnancy.
- The EPAU had a five bedded day ward which enabled women to have their treatment on site without the need of transfer to another area. The area was also used for gynaecological admissions. Women were able to be admitted on to the EPAU if there were any delays for discharge on the gynaecological ward. Women were able to be discharged home after their procedure from the EPAU or transferred on to the ward when a bed was available. Senior staff on the gynaecology ward told us this system ensured women had their operations in a timely manner and operations were not cancelled due to lack of available beds. The gynaecology performance dashboard showed that between June 2014 and June 2015 two patients had their operations cancelled in August 2014.
- Women did have 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 for 92% of patients to be on a waiting list for less than 18 weeks (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 was 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. 99.7% of women were booked for ante natal care by 12 weeks and 6 days gestation (April 2014 to March 2015). This exceeded the trust and national targets of 90%
- 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 part of the ward and contained a bed, chairs and hot drinks making facilities to ensure people were as comfortable as possible. The unit had the facilities to

ensure the baby was able to stay on the unit and not be transferred to the mortuary. This allowed women to stay with their baby for a long as they required without having to leave the suite to visit the mortuary.

- 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 through her pregnancy.
- Trained nurses on the gynaecology ward worked as 'link' nurses to provide support, and up to date guidance to staff who worked on the ward. The link nurses attended regular updates and training in a variety of subjects such as breast care, tissue viability and oncology. They disseminated the information to ward staff to ensure they met the individual needs of patients.
- 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 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

- The maternity and gynaecology dashboards monitored the amount of complaints received. The maternity dashboard displayed information from April 2014 to March 2015. We saw the service had received 17 complaints during that time frame. We saw complaints had been investigated and a presentation detailing themes of complaints was delivered to midwives. Poor communication from staff was a theme of some complaints. Staff received further training, particularly for conversations over the telephone to ensure they communicated effectively with women and their families. 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 these boards 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.
- Senior managers told us in a response to recent concerns raised by pregnant women they were about to conduct a pilot study at Basingstoke and North Hampshire Hospital 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.

Maternity and gynaecology

There was a strategy and vision for the service which was focussed towards the development of a new hospital. Staff and the members of the community had been consulted about the changes to service provision and had been involved in the architectural design of the new building. Short term strategies had been developed to ensure staff were ready for the move 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 also 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. 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 the delivery of care. Maternity risks were discussed at the weekly 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.

- Monthly staff meetings were held by the senior sister on the gynaecology ward. Audit R results were discussed along with ward performance, staff training and complaints received.
- There was a dedicated risk manager for the service who worked across all sites in the trust. We saw from minutes of meetings that all risks and incidents were presented at risk meetings and the risk manager ensured learning was shared across the trust.

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. Two members of staff told us "they know my name and always ask how I am when they see me"
- Consultants we spoke with were positive about senior members of the trust team. One consultant told us "there is excellent management here "and "they still listen and respond".
- 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 is like".
- 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 gynaecology ward had won the Director of Nursing award for team work in 2015. They had also won a rotary club award two years previously and had been nominated for awards consistently over the past few years. The awards were displayed on the ward alongside a sign which said "a unit to be proud of". Nurses and managers told us they were immensely proud of their awards.
- 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 were also 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. 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 ongoing 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 Basingstoke and North Hampshire Hospital provided care for children and young people up to and including the age of 18.

The service included the G2 paediatric inpatient ward with 28 beds and a high dependency close observation room, a Paediatric Diagnostic and Assessment Unit called Charlie's Day Unit, a day surgery unit (covering ENT, Eye clinic, dental and oral maxilla-facial surgery) with 6 beds, and an outpatient department.

There was a level two neonatal unit with 14 cots, of which some were designated intensive care and for babies who required additional support. During our inspection there were no children were in residence. 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. The community paediatric nursing team was also based in the hospital.

The Firvale Unit was a purpose-built joint-funded respite care facility that catered for children and young people with health needs, learning disability or challenging behaviour. We did not inspect this unit.

During the inspection we visited all areas of the paediatric service. We talked to nine parents, three young people (two of whom were teenagers) and 35 members of staff. This included support workers, play leaders, nurses, senior managers, senior clinicians and the clinical leads. We observed care and looked at more than 130 records relating both to patients and the running of the service. We reviewed performance information from and about the service.

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 on the weekends. Discharge summaries to GPs had not always been completed in a timely way. This meant that GPs had potentially not been informed of their patients' discharge from hospital or what treatment they had received We identified this area of concern to the trust and at the time of our unannounced visit all discharge summaries had been completed by senior doctors and consultants.

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.

Services for children and young people

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

A LEGO brick Model, designed by a play leader, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension. The model had been adopted for use in other hospitals.

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. 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 service was provided by a local health trust and the trust used agency staff when there were delays.

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 trust. Consultants were providing additional medical cover but this practice was not sustainable in the long term

Incidents

- Between May 2014 and April 2015, there had been four strategic executive information system (STEIS) serious incidents recorded across the trust paediatric services. Two had been reported at Basingstoke and North Hampshire Hospital with one unexpected neonatal death. All incidents had been fully investigated.

- 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 processed 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.
- 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, the learning outcomes and actions taken following incidents.
- The duty of candour regulation states that providers of services must be open and honest with service users and other relevant persons when things go wrong with care and treatment.
- Most of the clinical staff we spoke with knew about the 'duty of candour' and demonstrated knowledge of what the regulation involved. However, some junior medical staff were not aware of the duty of candour.
- We saw evidence in action plans that confirmed that the outcomes of investigations been shared with the families concerned. This showed that the duty of candour was being applied.

Cleanliness, infection control and hygiene

- The clinical environments were visibly clean. Equipment was covered, 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 gel dispensers.
- We saw nurses cleaning toys, with cleansing wipes which they told us they did after every use
- The environmental audit of the G2 inpatient ward (January 2015) showed overall non-compliance above the trust standard of 95% with infection control standards: an "environment maintained to reduce the risk of cross infection". There was an action plan to address any areas for improvement.
- Infection control audits had been completed in 2014 – for example, hand hygiene and bare below the elbow audits. The feedback report (February 2015) identified that the neonatal unit hand hygiene audit scored 100% compliance. The G2 paediatric ward, the outpatients department and Charlie's day assessment unit scored 95% compliance with their weekly and monthly hand hygiene audits (February 2015).
- Staff had received infection prevention and control training as part of their annual essential training programme. Trust training statistics confirmed that 92.5% of nursing staff in acute paediatrics and 94.1% of paediatric medical staff had completed infection control training in 2014
- Strict aseptic control measures were in place in the day surgery unit.

Environment and equipment

- Charlie's day assessment unit had an adjoining waiting room, day bed ward and clinical store room, which were separated by two open doors. At the time of our inspection we noted that within the treatment room there was local anaesthetic cream, intravenous fluids and needles in child-accessible unlocked cupboards. This gave the potential for children to walk through the open doors and gain access. This was immediately brought to the attention of the ward sister as unsafe practice. The following day we returned to the assessment unit and the items had been removed to a safer location and we found the adjoining doors had been closed.
- All equipment seen in all ward areas had been PAT tested and was in date.
- Equipment suitable for babies, children and young people was well maintained in all clinical areas.

- Resuscitation equipment had been checked weekly and checking logs was seen to confirm this had been done. We saw that emergency trolleys were appropriately stocked and sited. They contained a range of paediatric appropriate equipment including cannulas, airways and defibrillator pads.
- A few staff members told us that cupboards in Charlie's Day Unit were broken. We saw the maintenance log which supported this. A cupboard door reported on the 23 July 2015 was still not mended. The maintenance book indicated the delay was due to staff sickness.
- Parents told us the high dependency room onG was cold and draughty. We spoke to the ward sister and clinical service lead. The problem affected the eight rooms on the south side of the building due to poor design. The problem was first reported more than 10 years ago. The trust's maintenance department built secondary double glazing units which were used from September for the winter and removed in March every year. Due to the unseasonal weather this summer the ward had purchased four new electric fires to place in cold rooms and were using rolled up towels to stem the draught.
- The environment on G2 paediatric ward was clean but in poor condition. Staff told us "the wrong paint" had been used to paint cubicle doors and that deep cleaning had stripped paint, leaving the doors looking unkempt. The issue had been raised with the maintenance department.

Medicines

- Pharmacists visited wards to check medication stocks against prescription charts.
- Children who were admitted with their own medicines were seen by the on-call pharmacist who checked logged and verified medication then secured it in the drug cupboard.
- The trust policy for Safe Management of Medicines was in line with National Institute for Health and Care Excellence (NICE) guidance.
- Medicines management was good. Medicines were stored in locked cupboards. Controlled drugs were stored in accordance with 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.

Records

- We reviewed 25 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. These summaries were not being completed by medical staff in a timely way. This has been identified as a risk on the risk register and an appropriate discharge summary was being developed

Services for children and young people

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 relationships with the local children's safeguarding and child protection teams and they 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. GPs, community services and safeguarding teams were notified where there were concerns that a child might be at risk of 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 and 96% of staff on the day surgery unit. Staff told us that most nursing staff had completed the training. We spoke to two junior doctors who had yet to complete the training. Courses were available and there were on-going training sessions
- Staff undertaking paediatric endoscopy were given notification of children who were vulnerable for example those who are known to have suffered physical harm. Staff are made aware to heighten their awareness of responsibility to offer emotional support.
- 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

- The trust's training figures for 2014 confirmed that 94.1% of medical staff and 92.5% of staff in acute paediatrics had completed all mandatory training.
- We talked with members of staff of all grades, and confirmed that 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 neonatal nurses were 89% compliant with basic life support training, with senior nursing team having achieved the "new-born life support qualification".

Assessing and responding to patient risk

- Clinical areas were using their own risk assessment tool based on incident triggers.
- The service 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.
- The Paediatric Early Warning Score (PEWS) was used trust-wide to monitor children and to ensure early detection of deterioration. Staff told us they would escalate concerns to medical staff. We reviewed five paediatric early warning score observation charts and found them to have been completed. 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
- The neonatal unit had escalation policies, for example, the "cooling guideline". All policies were readily available and were followed to ensure the timely stabilization of

neonates before transfer to specialist units. This was being achieved within the four-hour optimal referral time, which is compliant with the Thames Valley and Wessex Neonatal Network guidelines.
- 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.
- There had been two incidents in Winchester where children had required mental health support following their admission and immediate support was not available through the CAMHS team. Learning from these incidents had been shared and led to the development of a risk list tool which was being used in Basingstoke and North Hampshire Hospitals.

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. Staffing rotas for the week of 22 – 28 June demonstrated that there was always a minimum of two registered nurses at all times on G2 ward . The trust planned staffing was 75:25 registered to unregistered staff. This was being achieved on all shifts with average staffing levels at 80:20.
- Charlie Day Unit had two trained staff on each shift from 8am to 10pm.
- There was a band 7 sister who 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. Post-surgery there were two nurses per patient. Surgical lists were usually up to six patients per list but there was the capacity for 10.
- The neonatal unit met the British Association on Perinatal Medicine (BAPM) safe staffing guidelines and was staffed to establishment. Their staffing levels were matched against dependency scores (BAPM NNU dependency levels) with a red flag system. This gave the service the ability to bring in more staff according to need. This was achieved from the service's own bank of nurses who were familiar with the unit and had received specific training.
- The neonatal unit ran a 12 month rotational preceptorship training for newly qualified staff to ensure that staff were fully skilled in all areas.
- CAMHS services were being provided by a local mental health trust. However, G2 ward was using agency Registered Mental Health Nurses (RMNs), when required for patients with mental health needs requiring 1:1 observation to ensure their safety and the safety of other children on the ward.
- 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.

Services for children and young people

- 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.
- 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 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.
- There was a major incident folder with evidence of mock drills having been performed in Charlie's Day Unit.

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, on the weekends, when children did not get physiotherapy.

Discharge summaries to GPs had not been completed in a timely way. This meant that GPs had potentially not been informed of their patients' discharge from hospital or what treatment they had received We identified this area of concern to the trust and at the time of our unannounced visit all discharge summaries had been completed by senior doctors and consultants.

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 National Institute for Health and Care Excellence (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, such as the National Institute for Health and Care Excellence (NICE) guidance for "care of early onset sepsis". The neonatal unit had achieved a level three compliance with the Baby Friendly Initiative for breast feeding in 2015. The neonatal toolkit was in place and being used.
- The unit received joint advisory group accreditation for gastrointestinal endoscopy in 2013.

- Assessment and treatment given was in line with British and Irish Orthopaedic Society guidance. Care interventions were based on the latest NICE guidelines. Special Educational Needs and Disability (SEND) guidance was used for children with complex needs.
- The Manchester triage tool was in use. This tool determines the priority of patients' treatments based on the severity of their condition and is widely used in the UK.
- 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 14. 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 BNNH included record keeping, safeguarding and rehydrating children with diarrhoea and vomiting under five years. The audit had been completed with an action plan for improvements.

Pain relief

- A pain assessment tool was used to identify and manage pain in children. The pain assessment chart was available and completed in each patient's clinical records.
- There was access to an anaesthetist 24 hours a day seven days a week to give advice on paediatric pain relief.

Nutrition and hydration

- The hospital had achieved the "Baby Friendly" Accreditation level three in the neonatal unit in October 2013. 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 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 Basingstoke and North Hampshire Hospital scoring 24.4% against the English 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 that Basingstoke and North Hampshire Hospital had met or exceeded the five standards required in the audit. For example 85% of women should receive a dose of ante-natal steroids; the audit showed that 89% of women at BNHH had received ante-natal steroids.

Competent staff

- The NHS national staff survey 2014 showed that 81% of staff across the trust had received job-relevant training/ learning in the previous 12 months.
- The neonatal nursing team were Qualified in Speciality (QIS) according to recommendations of the toolkit for High Quality Neonatal Services Department of Health (DOH 2009), achieving 70% trained nursing staff and 80% QIS.
- Newly-qualified nurses rotated within the paediatric department one year preceptorship programme: this enabled them to gain experience and knowledge in all associated clinical areas.

- Student nurses gave us very positive feedback, saying they had felt fully supported throughout their placements. Regular training sessions were held on respiratory conditions, diabetes and oncology, and were available for all staff to attend. Staff told us that meetings tended to happen on the Basingstoke site rather than at Winchester which made them easier to attend.
- Staff told us they received regular monthly supervision sessions and were encouraged to speak to their line managers sooner if they had any problems.
- 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.

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 weekends at the hospital. 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.

Seven-day services

- 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.
- 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 access to trust policies and procedures, which were available in hard copy or on the trust's intranet.
- Folders containing standard operating procedures which were visible and accessible.
- Discharge summaries to GPs were not being sent within 48 hours. We found 90 outstanding discharge summaries on Charlie's day assessment unit and 40 outstanding discharge summaries on G2 paediatric ward. This meant that GPs had not received information about a child's admission, treatment and care and discharge from hospital.
- Medical staff identified that the delays were being caused because of a lack of middle grade doctors and changes to the hospital's electronic discharge summary page which had lengthened the time taken to complete summaries. This was on the paediatric risk register and many GPs had contacted the trust about delays. The system was being updated. However, staff told us that GPs had agreed to accept verbal discharge summaries over the phone from February 2012 in the interim. However, patient records did not include evidence of this and during our inspection the ward clerk on G2 took a phone call from a GP complaining that they had not received a discharge summary for their patient. We were told this was a regular occurrence.

- We feedback our concerns to the trust to immediate action to rectify this. During our unannounced inspection we found that the discharge summaries had been completed senior doctors and consultants.

Consent

- Staff confirmed that patient consent would be sought before 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 being obtained in the paediatric outpatient department.
- We observed as part of one preoperative child's journey that 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.

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.

Children's emotional and social needs were are highly valued by staff and was embedded in

their care and treatment. LEGO brick Model, designed by a play leader, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension. The model had been adopted for use in other hospitals.

Compassionate care

- We observed many examples of compassionate and understanding care being delivered by friendly, approachable and committed staff.
- 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 children's patient survey (21014) 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 however the question relating to "Do patients feel listened to" for 8 – 15 year olds scored higher than other trusts.
- Staff used age appropriate communication. We observed excellent interactions between patients, consultant's nurses and parents. For example, one parent told us "When the doctors and nurses talk about treatment they talk straight to my child. They ask their opinion and seek approval which is amazing. I might as well not be here".

Services for children and young people

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-operation procedures to small children via story books showing them airways and other equipment with use of dolls to help lessen anxiety and helped to prepare children psychologically for theatre and procedures.
- As part of a university study module, one of the play leaders had made an MRI scanner out of LEGO bricks. This came with figures that went inside the scanner and a story book which described the whole procedure. There was also a set of head phones to play with and wear and a selection of stories and music that children could choose to listen to whilst in the scanner.
- A pre-scan visit to the MRI department could be arranged if children wanted to see it. The play leaders told us the radiographers within the department had been very pro-active with the project as its introduction had made children far less stressed when attending. The LEGO brick MRI scanner and training has been rolled out for use in other hospitals and won an in-house hospital "WOW award" for innovative practice.

Emotional support

- 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.
- Staff on G2 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 support offered where required.
- We saw examples of nurses and doctors offering emotional support to parents and in the neonatal unit we read many letters from parents thanking the staff for the emotional support and care they had received.

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 was an extendable 48-hour open access for discharged children via the "Green Card" temporary open access system. 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

- The Paediatric Assessment Unit (PAU) called Charlie's Day Unit, was helping to reduce the volume of children seen in community and in the ED. The unit was opened from 8am to 10pm. There are direct GP referrals to a paediatricians in Charlie's Day Unit (CDU) so that children do not need to attend A&E. There is open access for children with long term conditions. Parents can call to say their child and they are triaged to either CDU or A&E. Referrals to the ward or CDU could be made by ED, the community nursing team and GPs.
- Day surgery covering (covering ENT, Eye clinic, dental and oral maxilla-facial surgery) was done at the

Basingstoke diagnostic and treatment centre in the adult unit. Patients were pre-assessed two weeks before on a Sunday and consented on day of operation. On alternate Wednesdays, patients were pre-assessed in clinics and general surgery was done in the day case unit and recovery was on G2 paediatric ward. There are 4 cases per list. The same nurses were used for pre-assessment clinics and in-patients wherever possible.

- The day surgery unit worked in partnership with Southampton hospital regarding provision of children under 1 year old
- There was a level two Neonatal Unit (NNU) with 14 cots for babies who require short term intensive care. This comprised three intensive care unit (ITU) beds, three 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 services. However, patients requiring assessment and care for less than three days were cared for by RMNs booked by the trust via an agency.
- Children with cancer were supported by joint working with the local Naomi Hospice. Children with specialist requirements for example oncology were cared for on both the paediatric ward and at Naomi House Hospice. Staff told us they had direct access to all of the policies and procedures from the Hospice 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 based in the hospital.

Access and flow

With the exception on CAMHS patients. Children and young people between the age of 16-18 are given the choice as to whether they wish to be cared for on the paediatric or adult ward.Young people known to the service over the age of 16 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.
- There was not a waiting list for surgery.
- 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.

Meeting people's individual needs

- 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.
- Health promotion information and access to local services was available for children and young people.

- Information on how to access hospital services was available for people via information leaflets and on the trust's internet web-page.
- Most information leaflets seen were available in languages other than English, such as Polish and Nepalese. This was in response to the strong local Polish and Nepalese communities. Leaflets were available in other languages via the internet.
- Staff reported there was access to an interpreter and translation services should this be required. The ward sister showed us available information to support people with different languages and cultures.
- Children came to Charlie's day unit to have bloods taken by paediatric trained nurses. This helped to lessen children's distress by having child friendly and specifically skilled nurses performing the procedure.

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 may make a compliant or contact the patient advice and liaison service (PALS).
- Complaints were discussed at the services 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 assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated 'well-led' as good.

The service 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.

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 descriptions 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. It was identified that the service had "more work to do" in terms of cross site joint-working, particularly with medical staff.
- 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.
- Our discussions with managers demonstrated they were passionate and committed to delivering high quality and patient focused care.
- 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

- 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.

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 of 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	Outstanding
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 provided end of life care services at Basingstoke and North Hampshire Hospital as part of the cancer services unit within the surgical services division.

The specialist palliative care (SPC) services formed part of the North Hampshire specialist palliative care service and provided specialist palliative care to the Basingstoke and North Hampshire Hospital and the community of north and mid Hampshire. All the services were NHS managed and belong to the trusts cancer services business unit within the surgical services division.

During our inspection we visited eight wards where end of life care was provided in addition to, the bereavement centre and the mortuary. We spoke with five patients, three relatives and 21 staff, including staff nurses, health care assistants, ward sisters, junior doctors, senior doctors, mortuary staff and the bereavement staff. We observed interactions between patients, their relatives and staff, considered the environment and looked at 19 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and eight medical and nursing care records. Before our inspection, we reviewed performance information from and about the hospital.

Summary of findings

End of life care at this hospital was "outstanding".

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, a holistic patient-centred approach was evident.

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 excellent 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 and the low staffing levels in the mortuary.

End of life care

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

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

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. There was an identified shortage of side rooms for those patients identified as being in the last hours of life.

Are end of life care services safe?

Good

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

We rated safe as "good".

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

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

We saw elements of good practice including the safe management of medicines and the safe management of patient records.

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

Staffing levels were reported to be sufficient to ensure end of life patients received safe care and treatment. Where staffing levels were low, for example in the mortuary the trust had taken action to ensure that the lone member of staff's safety was always protected.

Staff reported good access to the specialist palliative care team and there were 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, two incidents relating to end of life care had been reported at this

hospital. These were a patient fall 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. One member of staff was able to describe an incident they had raised and how this was discussed at a weekly performance meeting on the ward.

- 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 eight medical and nursing case notes for 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 and, patients and their relatives.
- During our inspection we saw 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 eight patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.

Safeguarding

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. 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 eight 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, 8am to 4pm seven days a week.
- Telephone support out of hours was provided by one of four palliative care consultants, on a rotational basis.

Mortuary staffing

- The staffing establishment across The Royal Hampshire County Hospital and this hospital was; 2.0 whole time equivalent (WTE) band seven mortuary managers; 1.0 WTE band six; 1.0 WTE band five and; 2.0 WTE band four.
- During our inspection we visited the mortuary at this hospital. We met with a senior member of staff who was currently working alone because of staff sickness. The member of staff told us they worked full time hours in addition to, covering 'on-call' arrangements at this mortuary. They also told us, due to working alone, of manual handling transfers requiring four members of staff. We were told arrangements were in place to support this individual through the use of staff from The Royal Hampshire County Hospital and the use of bank staff. However, this was on an 'ad hoc' basis. We were concerned staffing levels in this mortuary did not ensure that this member of staff's safety was always protected. We raised this with the chief executive and were told the trust was aware of the challenges faced and the health and safety team and manual handling team had met to review appropriate support within the mortuary. The risks associated with being short of staff was identified on the departmental risk register in July 2015 and actions to mitigate the risks had been put in place. Post mortems were to be completed at The Royal Hampshire County Hospital to prevent single handed lifts and, where additional staff were required to assist in a manual handling procedure, portering staff were to be contacted to assist.

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. These 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.

Overall we rated effective as "good".

In response to the 2013 review of the Liverpool Care Pathway (LCP), the trust had developed the patient-centred 'achieving priorities of care' (APoC) documentation. Evidence based assessment, care and treatment was delivered in line with national guidance and National

End of life care

Institute for Health and Care Excellence (NICE) quality standards and local guidelines were in place. These were followed for the effective management of the five key symptoms at the end of life.

Patient's symptoms of pain were 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. There was 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 19 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Approximately 20% of the forms we looked at were incomplete. They did not indicate, in the medical notes, where a discussion had taken place with the patient, patient demographic details such as date of birth and address and did not contain a reason for the DNACPR.

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 eight 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 were audited every three months. The results were discussed at 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.
- We observed an older people's consultant ward round during our inspection. One patient had been cared for on the APoC pathway, however, the consultant had

noted the patient was improving. A decision was made to take the patient off the APoC pathway and review daily. This demonstrated the consultant's understanding of the APoC pathway.

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 patients pain. We reviewed eight 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 eight 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.
- We observed in one patient's documentation where nursing staff had been assisting the patient to drink. The patient had a red coloured beaker, this alerted all staff to offer assistance with fluids.
- 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' (DNA CPR) competency training and training plans for junior doctors.
- All the staff we spoke with told us they had received some form of training in end of life care since working at this hospital. This involved 'face to face' training on the ward, 'drop-in' training sessions and, formal study days delivered by the specialist palliative care team.
- The palliative care service supported a comprehensive internal and external training programme to improve the awareness and quality of palliative care delivered by clinical staff at the hospital.
- Four palliative care study days were held per year, two for health care assistants (HCA) and two for registered nurses. The study days alternated between two hospital sites at the trust.
- End of life and palliative care training was delivered on both medical and nursing induction days. This included input from the chaplaincy and bereavement services. At the time of our inspection some members of the specialist palliative care team (SPCT) were delivering training for the new doctors due to commence employment at the trust in August 2015.
- 'Grand rounds' took place at the trust. Grand rounds are an important teaching tool and a ritual of medical education and inpatient care. They consisted of presenting the medical problems and treatment of a particular patient to an audience of doctors, residents and medical students. The SPCT had, on occasions, been invited by a consultant to provide end of life training during these rounds.
- 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.
- 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.
- The North Hampshire specialist palliative care multidisciplinary team met weekly via video-conferencing facilities between this hospital and a nearby independent hospice to discuss new patient referrals, patients with complex symptom and psychological / social needs, patients requiring management plan reviews, families with complex bereavement needs, patients transferring between teams, patients making out of hours contact with an element of the SPCT service on a regular basis, patients identified as having been commenced on the 'achieving priorities of care at end of life and, patients identified as being eligible for continuing healthcare funding for end of life discharge.

End of life care

- The trust was developing an electronic palliative care co-ordination system. Electronic Palliative Care Co-ordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care at the end of life. At the time of our inspection staff within the trust were made aware of those patients known to end of life and palliative care services through a 'tagging' system on the patients electronic care record. Key details regarding patient preferences were shared with external providers and GP's through a twice-weekly video conference.
- 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 an independent hospice or the consultant on call who were contactable via the trust switchboard. Nursing staff reported having good access to the team. One member of staff said "you don't feel like you're on your own, we want to get it right".
- 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 from 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 eight medical and nursing records of patients in the last days of life. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and patients were supported to make decisions. However, one patient had received a deprivation of liberty safeguards assessment. The assessment suggested an order by the court of protection authorising deprivation of a person's liberty should have been applied for but this had not taken place. We brought this to the attention of the ward sister who told us, this had not been applied for because the patient was on the achieving priorities of care pathway. Following discussions with the patient's consultant and our observations of the patient, it was clear the patient was in the last hours of life.
- 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 19 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Our review showed 15 out of 19 DNACPR forms had been fully completed. Approximately 20% of the forms we looked at were incomplete. They did not indicate, in the medical notes, where discussion had taken place with the patient, patient demographic details such as date of birth and address and did not contain a reason for the DNACPR.

Are end of life care services caring?

Outstanding ☆

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

End of life care

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". Medical and nursing staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner. We saw where staff provided practical help and information to visiting relatives for example about, car parking, facilities to get food and, visiting times. 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.

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.
- On ward E1 we observed 'outstanding' care by all the staff including nurses, doctors and housekeeping staff. Staff were highly motivated and inspired to offer care that was kind and promoted patients dignity. All the staff on the ward were passionate about the end of life care they delivered and told us how they felt it was important to them that patients were comfortable in their last days or hours of life. The ward housekeeper told us they sat with the relatives and provided practical help and information to visiting relatives for example about, car parking, facilities to get food and, visiting times. Staff told us, due to the specialty of the ward, many patients remained on the ward for long periods of time, during this time they built trusting relationships with both the patient and their relatives. We were told relatives would often return to this ward post bereavement and staff were often invited to attend funerals.
- During our inspection we observed a ward round where the specialist palliative care team reviewed all those patients known to their services. The team were caring to the patients and information was delivered in a sensitive manner. One patient was blind; the consultant ensured the patient knew who was in the side room before they began their consultation.
- 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.
- The bereavement service supported the trust to provide a sensitive and specialised service when a patient died. The bereavement officer had been in post for many years and provided a holistic and caring service 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.
- The trust 'care of patients at death' policy stated patients must continue to be treated with dignity, respect and in privacy after death. Between April and August 2014 an audit of patients received into the mortuary was undertaken. Results were audited against standards identified in the policy and were largely positive. Findings were shared with ward managers, to discuss with ward teams and advice on how ward teams should manage care of patients at death was to be sought from the mortuary teams if required.
- 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 five patients and three relatives during our inspection. Feedback was consistently positive about the way staff treated patients receiving end of life care. Where one patient was in the last hours of life and staff were unable to nurse the patient in a side room an offer had been made to move the patient to another ward. Relatives of this patient had declined the offer of a side room in favour of the patient remaining on the ward. Another patient told us "They {the staff} are very caring… The care couldn't get any better".

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 210 deaths at this hospital, of these 50 questionnaires had been given out with a response rate of 24%. 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 sometimes or 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.
- We spoke with five patients during our inspection. All had been identified as being in the last 12 months of their life. All five 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 "The doctor is nice… They {the doctors} explain everything very well".
- We spoke with three relatives during our inspection. All three relatives spoke positively about the care their loved ones had received. One relative told us they had been telephoned to come and speak with the patient's doctor, they felt they received a good explanation about the care and treatment of the patient and felt the information provided by the doctor had helped them to come to terms with the patient's condition.
- During our inspection we were told of only one room available for relatives to stay overnight, the 'Libby' room. Nursing staff told us relatives could visit the patient at any time and were able to stay by the patient's bed in a recliner chair. Drinks were provided by the wards and 'snack boxes' would be made available from the hospital kitchen.
- 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 the chaplaincy team by names and said a member of the team would visit the wards at any time. A member of the 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 a member of 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. The chaplaincy department were able to access faith leaders from other denominations if requested.
- 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?

Outstanding ☆

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 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 could be 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

- The hospital did not have dedicated end of life beds. 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. One relative told us they wanted the patient to remain on the ward because they would not have liked to be nursed in a side room.
- 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 eight ApoC documents and saw where the patients preferred place of care/death had been documented.
- 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.

- Between January and March 2015 there were 451 inpatient deaths across this hospital and The Hampshire County 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".
- We visited the radiotherapy unit during our inspection. This was available to end of life patients in the Basingstoke area for palliative radiotherapy. The radiology service lead told us patients had previously had to travel to Southampton for this treatment.

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 on the wards and in the chaplaincy department demonstrated a good awareness of the language and cultural needs of the local community. Staff told us the process they would follow should they require an interpreter and were able to access multi-faith leaders through the chaplaincy department.
- The spiritual needs of patients were identified in the achieving priorities of care (APoC) documentation. One nurse told us the APoC document reminded them to ask about the patient's spiritual needs. 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.
- Free car parking for those families visiting patients identified as being in the last days or hours of life was 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 staff 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 eight 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 took place when a patient had a rapidly deteriorating condition and was 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.

- 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 this hospital to their home under continuing health care 'fast track' funding was undertaken between March 2014 and March 2015. The National Framework for NHS Continuing Healthcare and NHS funded nursing Care (2012) standards are that 100% of patients referred to the specialist palliative care team (SPCT) for assessment of suitability of fast track funding are assessed within 24 hours and 90% of patients whose preferred place of death is at home are discharged within 48 hours of assessment with the correct level of care. Results from the audit showed 100% of referrals for 'fast track' assessment were seen and assessed by the SPCT within a 48-hour time frame and the average time from sign off to discharge was consistently over 48 hours. This had significantly risen over the year from the average number of days between March and May 2014 being 6 days to 46 days in between January and March 2015. However, the 46 days taken to discharge had occurred with one patient only. 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, three related to end of life care at this hospital. Complaints were responded to in an appropriate and timely way. We saw, in all three complaints, where an apology had been given by the chief executive, who viewed every complaint submitted to the trust. Improvements were made to the quality of care as a result of the complaints. For example, the process for ensuring post mortem dates were checked and verified had been reviewed and updated following a complaint relating to mortuary services.
- 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, included in a bereavement pack, 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 specialist palliative care team 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 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.
- 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 no 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 staff shortages. The risks associated with being short of staff were identified on the risk register in July 2015 and were immediately reviewed the week following our inspection. In addition, there were a number of actions that were underway to resolve the issues faced. These included the plan to liaise with the local Coroner to manage and limit post mortems on this site. This meant workloads could be planned between this hospital and The Royal Hampshire County Hospital. We were told by senior members of the trust board that longer terms plans for the service were being considered.

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 they 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 written "I love the 'hands-on' part of my job and the service I give to patients and their families to help them through a hard time. I am proud that I can make this the least stressful possible for relatives".

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, including nursing, medical, allied health professional and ancillary, within end of life services

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

- The 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	Good
Effective	Not sufficient evidence to rate
Caring	Outstanding
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Basingstoke and North Hampshire 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 trust provided 174,560 new adult's outpatient appointments and 379,484 follow up appointments

The diagnostic imaging department was open for scheduled and unplanned appointments from 8am to 5.00pm and offered plain film radiography, CT, ultrasound, fluoroscopy, Interventional radiology and breast imaging. MRI scans were also offered between 7:00am and 9:00pm 7 days a week. The service was available 24 hours a day for emergency radiology.

During the inspection we visited the outpatient department and diagnostic imaging services as the cardiac physiology service and the breast unit. We spoke with 37 patients and 42 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

The outpatient and diagnostics imaging services were 'good'for safe, responsive services, and well-led services. It was 'outstanding for the delivery of a caring service.

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

The environments were visibly clean and staff followed infection control procedures. Equipment was well maintained and medicines were appropriately managed and stored. 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 outpatients. Interventional radiology there was evidence of the WHO checklist being completed and patient protocols in place. However, in the Candover Unit national guidelines for interventional radiology were not always followed the trained staff to be available in an emergency.

Outpatients and diagnostic imaging

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

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

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

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

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

'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. The hospital had plans to address issues regarding 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 required further development in the outpatient department to monitor risks and quality although these were well developed in diagnostic imaging.

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Nurses and radiographers spoke highly of their immediate line managers and told us they worked in strong, supportive teams which they valued.

There were some 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 following to support and implement positive changes within the department that staff members themselves had recommended.

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

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

We rated safe as good.

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

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

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

Most records were available for clinics and, if not available, temporary files and test results from the electronic patient record were used 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. At the Candover facility there was no medical presence when administering intravascular contrast which was in direct conflict with standard one of the Royal College of Radiologist guidance.

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

Incidents

- In outpatient clinics and diagnostic imaging services, incidents were reported on the trust electronic reporting system. Staff felt confident with the process for reporting incidents and confirmed that feedback was disseminated during team meetings, to share learning and improve patient outcomes.
- There had been no serious incidents requiring investigation (SIRI) within the outpatient and diagnostic imaging departments.
- 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.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic imaging areas were visibly clean.
- There was good evidence of trust infection control processes being adhered to. There was an infection control team within the trust who visited departments and provided feedback in infection control performance. In addition to this, outpatients and diagnostic imaging nominated a staff member who conducted departmental infection control audits in relation to hand hygiene, with compliance across both departments being between 98% and 100%. There were no notice boards in waiting areas to inform patients of the department infection control performance
- 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

- 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 in date.
- The environment in outpatients and diagnostic imaging was well maintained
- In the outpatient department, managers had a list detailing all of the equipment within the department and when it was due for a maintenance check. This enabled staff to have an overview of the testing dates. We looked at 19 pieces of equipment. The portable appliance testing were all in date.
- There was appropriate access to resuscitation equipment in each clinical area
- The resuscitation trolleys in outpatients and diagnostic imaging had been checked daily and all the equipment was observed to be in date.
- 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.

Outpatients and diagnostic imaging

Safeguarding

- All staff within outpatients and diagnostic imaging had completed their level 2 safeguarding training. 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.
- Staff knew how to report safeguarding concerns. They knew how to access further advice on the trust intranet if required, and had felt well supported by their line managers if they had encountered more complex safeguarding issues.
- 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 outpatients and diagnostic imaging was up to date with a 90% - 94% compliance rate, which exceeded the trust target of 80%.
- At the Candover facility, 95% of staff had completed their mandatory training.

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
- At the Candover facility, (situated just outside of the main hospital building), radiographers were supported by a radiologist from the main hospital site and from a resident medical doctor (RMO) who was also based outside of the Candover building. When administering intravascular contrast, radiographers would contact the radiologist to let them know that they were about to administer contrast, the radiologist was not present when this procedure took place. This contravenes standards published by the Royal College of Radiologists (RCR) for intravascular contrast administration in adults, which states in standard one that 'An individual trained in recognising and treating severe contrast reactions, including anaphylaxis, should be immediately available in the department where contrast is being administered'.

Outpatients and diagnostic imaging

Nursing/radiography staffing

- In the outpatient department there were nine registered nurses (RN) and 26 health care assistants (HCA). There were two vacancies, one for a RN and the other for a HCA. Recruitment was underway and candidates were due to be interviewed within weeks.
- Bank staff were used to fill gaps in staffing. Induction was thorough. New bank staff were initially supernumerary and had to complete a competency checklist before being able to work unsupported in clinical areas. No agency staff were used.
- Outpatients had just been informed that they were to provide placements for student nurses. The first student was to commence placement in September 2015.
- 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.
- 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 10 consultant radiologists working at Basingstoke and North Hampshire Hospital and they were able to sub specialise. Consultants confirmed good working relationships with junior doctors within the trust.
- A resident medical officer (RMO) was assigned to the Candover facility and was based within the main hospital site.

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 outpatients department.

There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in rheumatology and ophthalmology. 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.

Outpatients and diagnostic imaging

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 adhered to the 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 to obtain 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 2.2 to 2.0; the rate for England was 2.4 (January to December 2014)

Competent staff

- Most staff had completed an annual appraisal and documentation was shown to confirm this. Where appraisals had not been completed, line managers provided evidence as to why they were outstanding, for example; where staff had been on maternity or long term sickness absence. 94% of outpatient staff had received their annual appraisal, 96% had completed their appraisal in diagnostic imaging.
- 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. Two health care assistants were commencing their nurse training in September 2015 and had been sponsored by the trust. 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. Their first student nurse was due to join the department in September 2015.The

- 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 8:00am – 5:00pm.
- In diagnostic imaging, appointments were available Monday to Friday between 8:00am – 5:00pm with the exception of MRI scans which were provided between 07:00am – 9.00pm seven days a week. Two radiographers were available overnight and at weekends for inpatients that 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.

Outpatients and diagnostic imaging

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.

Some examples included when clinics were running late recognising that this causes a lot of stress for patients, particularly if they had parking tickets that were due to expire. Nurses often offered to go to the parking office and revalidate patient's parking tickets for them, which allowed patient's to focus on their appointment and remove the worry of parking fines.

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.

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 is evidently 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. One patient told us, 'the staff here are so encouraging and caring, they respect my wishes by including my daughter in discussions, which means a lot to me. My daughter has to accompany me to hospital appointments due to my disability. It is outstanding here'
- Staff provided examples that demonstrated where they had gone the extra mile to support patients. Some examples included when clinics were running late recognising that this causes a lot of stress for patients, particularly if they had parking tickets that were due to expire. Nurses often offered to go to the parking office and revalidate patient's parking tickets for them, which allowed patient's to focus on their appointment and remove the worry of parking fines. Another example was provided during which an elderly, frail patient who had travelled some way to get to the hospital using public transport was concerned about travelling home in the dark due to a late running clinic. Nursing staff spoke with the consultant and it had been agreed that the patient's appointment would be brought forward to allow the patient time to travel home safely.
- 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.
- 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.

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. During one interaction, a patient living with dementia had arrived at the department in a

distressed manner. The patient had been accompanied by a relative who was tearful due to the distressed state of the patient. A nurse went straight toward them and started talking to the patient, calmed the situation, found comfortable seating and made the patient and relative a cup of tea. This was one example of many such interactions observed throughout our visit.

- Staff treated patients with dignity and respect, recognising individual patient's needs. For example, one patient told us, 'My relative passed away in this hospital. It was sometimes difficult for me to come in for appointments as I felt quite upset, but the nurses remember me each time and they always have a chat with me. I can't speak highly enough of the care here'. This is just one example of where staff had highly valued a patient's emotional needs.
- 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, 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 10%; 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 reviewed to ensure the timeliness of re-appointments for their condition.

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

About one quarter of patients were not seen within 30 minutes in clinic. Staff provided explanations and information about delays.

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

- 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.
- The breast unit offered 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 confirmed, 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 diagnostic imaging department offered a GP walk in appointment service from 8am to 4pm on Monday to Friday.
- The Candover facility provided private outpatient and diagnostic imaging services. Referrals were made and

appointments arranged by a patient's GP and could be emailed or made over the telephone. The trust also sent out letters to outpatients offering them the opportunity to become a private patient if they wished. Staff told us that there had been a high uptake of patients choosing the Candover facility as a result of the letters being sent.

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 had decreased from 8.5 to 7.0% (January 2014 – 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.
- Between January 2015 and April 2015 an average of 10% of outpatient appointments across were cancelled each month by the Trust at the hospital. The England average was 7%. The trust told us that this was primarily due to sickness, annual leave and study leave. A further 10% 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, 24% 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.

Outpatients and diagnostic imaging

- 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 lived 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. Staff told us that they were able to access a learning disability specialist nurse who supported the trust in caring for patients with a learning disability.
- Nursing staff followed an outpatient clinic plan for each speciality, this aided new staff in providing a seamless service for patients. Written within each plan was for staff to ensure that all patients who had been waiting a significant amount of time, who were diabetic or distressed were offered refreshments.

Learning from complaints and concerns

- Information on how to make a complaint was not displayed.
- In 2014/15, the outpatient department received only one complaint about a breach of patient confidentiality. There were six complaints in diagnostic imaging regarding. One regarding delayed or cancelled appointments, one regarding treatment and four about staff attitude. These had been responded to appropriately
- Across the trust the majority of speciality outpatient complaints were for cancelled appointments and waiting times. The staff at 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?

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 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. The trust were aware that improvements were to be made in relation to the outpatient pathway, particularly focussing on cancelled appointments and an action plan, which was in the early stages of development was being prepared to tackle this. The plan was being considered for implementation at the hospital. Staff were not aware of how the strategy would develop in their departments. In diagnostic imaging there was an action plan planned to increase the skill mix of staff, the capacity of services and service integration across sites. This had had yet to be considered at divisional and trust board levels and interim actions were not specified.

Governance processes in the outpatient department were at divisional level. Information about incidents and patient experience was shared, but there was less information on clinical risk, complaints and audit to monitor the quality of the service and risks. Risks were collated at service and divisional level and the most serious, the availability of medical records, had been escalated to the trust board. Governance processes in diagnostic imaging were overall, well developed to manage risks and quality.

Staff were not clear about the overall vision and values of the trust but told us that the patient experience and the provision of high quality care was their main concern. Nurses and radiographers spoke highly of their immediate line managers. They continually told us that they felt well supported and valued. Staff told us that they enjoyed working for the trust due to the strong team support from colleagues. The CEO and Director of Nursing had a strong visible presence.

Outpatients and diagnostic imaging

There was local innovation to reduce the cancellation clinic rate. 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

- The outpatient service strategy was part of a clinical services review and was currently a set of proposals. The review was planned around the delivery of the a new critical treatment hospital. The review identified the need for general and locally based outpatient services which at Andover, Winchester and Basingstoke. The services would be consultant led with increased roles for advanced nurse practitioners. One Stop clinics and more complex procedures in outpatient clinics, as well as nurse led clinics were proposed as part of the discussion. Referrals could come through A&E, Assessment Unit via GP, walk-in, referral and consultants would be responsible for triage to plan appoint bookings and pathways.
- The service had short term priorities. Managers told us that improving capacity was one of their greatest concerns and the need to improve the outpatient pathway. There was an action plan, in the very early stages of development, to improve the focussed on the number of cancelled appointments. The plan was being considered for implementation at Basingstoke and North Hampshire Hospital.
- 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.
- 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. There had not been local actions to monitor patient's whose clinics were cancelled were appropriately followed up. However the hospital was piloting processes to reduce clinic cancellations.

Leadership of service

- Nurses and radiographers spoke highly of their immediate line managers. They continually told us that they felt well supported and valued. Staff felt confident that they could go to their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally. The staff in outpatients frequently saw the outpatient service lead and nurse manager.

- All staff felt that the CEO and the Chief Nurse provided a strong, visible presence within the trust. Most staff had spoken to the CEO and found her to be approachable and accessible. Staff did not feel that other board members were a visible entity within the trust.
- In diagnostic imaging it was felt that from senior management 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.
- It was evident that outpatients and diagnostic imaging had not fully integrated across the three trust sites, each site working quite differently despite the same leadership at senior management level. The local management recognised this and in diagnostic imaging there were plans in place which were seen during inspection, to move integration forward. This was not the case in outpatients. The breast unit however, had fully integrated and provided a unified service to all patients trust wide.

Culture within the service

- All of the staff we spoke to across outpatients and diagnostic imaging told us that the teams they worked in and the supportive relationships forged with their colleagues were the main reasons they enjoyed working for the trust. Most staff had been in post for a significant number of years and really felt part of the outpatients or diagnostic imaging team as well as part of the trust as a whole.
- 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 felt that this was working well and welcomed the opportunity to have a voice within the department.
- Staff told us about a link that allowed them, via email, to anonymously contact the CEO

with any questions, suggestions or concerns that they had.

- 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 periods 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.
- A project is underway within outpatients at the Basingstoke and North Hampshire Hospital to reduce the number of weekly trust cancelled clinic appointments. It is in its infancy but will be looking into the outpatient department holding the waiting lists for the individual specialities and addressing capacity issues. Initially, the project would look at one or two specialties with a view to rolling this service out to other disciplines.

Outstanding practice and areas for improvement

Outstanding practice

- The trust is one of only two designated specialist treatment centres in the country for treatment of Pseudomyxoma. This is a very rare type of cancer that usually begins in the appendix, or in other parts of the bowel, the ovary or bladder. The hospital has treated more than 1000 such cases. The diverse multidisciplinary team has developed the skills to help patients through this extensive treatment, and share their knowledge on international courses and conferences.
- Through audit surgeons working at then trust have changed practice world-wide, such as new techniques for the biopsy on operable tumours and the benefits of waiting six weeks after completing chemotherapy before performing liver resection.
- 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.
- GPs had access to electronic information held by the trust. This meant they were able to access electronic discharge summaries with up to dater information available about care and treatment patients had received in hospital.
- A LEGO brick Model, designed by a play leader, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension. The model had been adopted for use in other hospitals.
- Critical care career pathways were developed to promote the development of the nursing team.
- 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.

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 identifying patients with a learning disability.

Outstanding practice and areas for improvement

- Nurse staffing levels comply with safer staffing levels guidance.
- Resuscitation equipment is appropriately checked, sealed and tagged.
- Medicines are appropriately managed and stored in surgery.
- Controlled drugs in liquid form are managed and stored appropriately in all the medical wards.
- The early warning score is used consistently in surgery and a system is developed for use in outpatients.
- Venous thrombo-embolism assessment occurs on admission for surgical patients.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

The hospital should ensure:

- Uncontrolled access to, and observation of, the resuscitation room from short stay is prevented.
- X-ray warning lights for the resuscitation room work appropriately.
- 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.
- The separate children's area in the ED is visible in the main department and access in the main waiting room is restricted.
- Staff using the relative's room in the ED have appropriate security, such as a viewing window in the door and/or panic alarm.
- Staff maintain infection control procedures at all times.
- Medicines are appropriately managed and stored in maternity and gynaecology.
- Staff use and appropriately sign up to date approved Patient Group Directions (PGDs) in the eye unit in the ED.
- Continued action to significantly reduce the incidence of pressure ulcer and falls.
- Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed in Maternity and gynaecology.
- An early warning score system is developed for use in outpatients.
- Equipment in the Maternity unit is checked and documented as per trust policy.
- 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.
- Records on the gynaecology ward are stored securely to prevent unauthorised access
- The availability of medical notes for outpatient clinics continues to improve and this should be audited.
- National guidelines are followed when administering intravascular contrast in the Candover Unit.
- Staffing is improved in radiology to decrease high workloads.
- Staff in maternity have appropriate training to complete the new nursing assessment booklet.
- Staff from critical care who have been redeployed elsewhere in the hospital are able to return when a patient is admitted to the critical care unit.
- There are arrangements in place to support lone working in the mortuary.
- Clinical audit programmes continue to develop.
- Nursing staff receive formal clinical supervision in line with professional standards.
- Children's discharge summaries are completed within 48 hours.
- 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.
- Review the Critical Care outreach service at night.
- 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 AAU and facilities on and the eye day car unit to ensure patients privacy and dignity is not compromised.
- 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.
- Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.
- Information for patients is available in accessible formats.

Outstanding practice and areas for improvement

- 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.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments, and ensure patients have timely and appropriate follow up
- Complaints are responded to within the trust target of 25 days.

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 are sealed and tagged. · Medicines are appropriately managed and stored in surgery · Controlled drugs in liquid form are managed and stored appropriately in all the medical wards · The early warning score is used consistently in surgery and a system is developed for use in outpatients. · Venous thromboembolism assessment occurs on admission for surgical patients · Resuscitation equipment is appropriately checked and items are sealed and tagged.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

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.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: Staffing

Regulation 18 (1)

How the regulation was not being met:

The trust must ensure:

· Nurse staffing levels comply with safer staffing levels guidance.