This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Is this organisation well-led?**

To write this well-led report, and rate the organisation, we interviewed both executive and non-executive directors and a range of senior staff across the hospital. This included a range of clinical and non-clinical service and business unit leads. We met and talked with staff at all levels to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, policies, audits and action plans; board meeting minutes and papers to the board, external reviews, incidents and investigations. We also obtained feedback from patients and stakeholders.

**Leadership**

The new trust Chair and chief executive (CEO) were relatively new in post. They had recently built an experienced leadership team with the skills, abilities and commitment to provide high quality services. High calibre non-executive directors had been appointed some of whom were very new to the role.

Most of the board had resigned between our last comprehensive inspection in 2015 and early 2017. A new chair was appointed in November 2017. They had extensive experience in the health sector and had clear priorities for the roles of the board. The board development plans were well thought through and represented an appropriate investment in a new team with the challenges they faced. The Board had the relevant financial expertise across the executives and non-executives.

The CEO was appointed in July 2017. This was their first appointment as a CEO however they had worked extensively in senior management roles within the NHS and NHSI. They had clarity around the risks facing the organisation and showed commitment and focus on the work that needed to be done. They had the necessary skills, knowledge, compassion and integrity needed to lead sustained improvements across the trust. The Chair and CEO worked well together and provided much needed cohesive leadership.
The chief nurse was substantively appointed in January 2018 having worked as an interim at the trust for 3 months previously. They had extensive experience in NHS organisations and were described as “breathing life back into the nursing workforce”. They had clear priorities for improving patient care and for the empowerment of the nursing staff. They worked clinically one morning a week and were clearly passionate about the opportunities to improve within the Trust.

The medical director was appointed to the role in July 2017 having previously worked in the Trust as an associate medical director and lead for critical care.

The director of integrated governance was appointed in January 2018. They had extensive experience of governance within the NHS.

The Director of Finance was appointed in 2015. Previously he was Chief Financial Officer at another NHS Trust. A turnaround director (appointed in January 2018) was supporting the delivery of the financial recovery agenda.

The Director of Strategy and Performance was appointed in January 2018, having previously gained insight into the trust and its challenges while working in a related role at NHS Improvement.

The Director of Communications and Engagement joined the trust in December 2017 from a similar role in a neighbouring trust.

The Chief Operating Officer joined the trust in October 2017, having held the Chief Operating Officer role in another acute trust.

The core executive team had been employed by the use of values and skills based recruitment. Individuals had an agility to adapt portfolios to meet their skills and experience. We witnessed the executive team modelled inclusive supportive relationships.

NHS Improvement (NHSI) appointed an NHSI improvement director in July 2017. Their remit was to support the newly appointed chief executive, ensure a board was in place and have oversight of the quality improvement plan.

The chief executive had approached a workforce director who was employed by NHSI to cover the role in the absence of a substantive post holder. They were clear about the workforce challenges and worked closely with the executive team.

The executive team had established a leadership summit for leaders from across the trust. This had commenced in March 2018 and was due to be held every 6 months. All leaders from across the organisation were able to attend and each summit was focussed on a dedicated subject and led by an external specialist in the field.

The trust had an organisational and development strategy which encompassed leadership and talent management. However, this was due to be superseded by the workforce and organisational strategy which was being refreshed at the time of our inspection and was due to be launched following the publication of the organisational strategy in July 2018. The four key priorities were

- To develop the capability of our leaders to ensure we have the right people with the right skills in the right place at the right time, and the values and behaviours to achieve our priorities. Implementation of a Values and Behaviours based leadership development as an integral part of the culture change programme which will focus on a collective leadership strategy.
- With a new Executive Leadership team embarking on a Board Development programme aligned to the CQC Well Led Framework.
Development of greater visibility of where Talent is within the organisation and how this fits with needs and succession plans and have successfully obtained a grant from the NHS Leadership Academy for a Talent Software solution

A key priority will also be to secure a place on the NHS Employers Equality, Diversity and Inclusion Partnership programme.

Board Members

Our observation of a Board meeting in May evidenced appropriate challenge from the NEDs when compared to previous minutes of board meetings. This was confirmed in our conversations with stakeholders who attended the meetings.

Of the executive board members at the trust, none were British Minority Ethnic (BME) and 44.4% were female.

Of the non-executive board members none were BME and 33.3% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Vision and strategy

The trust did not have a current strategy which provided an organisational and clinical framework for the sustainable delivery of high quality care. The executive team had recognised the need for the development of a credible strategy which supported organisational plans and shared strategic priorities with stakeholders and partners. However this was still in development during our inspection and was due for adoption in July 2018.

The trust had identified that the organisational and clinical strategies were poorly defined. This had been documented as a risk on the board assurance framework. As a result of the absence of a well-defined strategy, focus had been diverted from core functions and had led to poor performance against regulatory and contractual demands and financial instability. There was an increased risk of patient harm, poor patient experience and an increase in staff turnover. Work had begun on the development of a new strategy in early 2018.

The trust had commissioned a baseline data report as the first stage in the development of the strategy and to provide a structured assessment of current performance. The report was developed through a range of interviews with clinicians, management and representatives from system partners and the community and was produced with support from an external management consultancy. Performance was assessed against three areas; system, trust wide and speciality level. Observations from the report concluded that there were a number of strategies in place which had been developed organically. Many had been developed in response to need, or from the enthusiasm or exasperation of staff. Without a coherent trust wide strategy the trust direction of priorities both internally and externally were not well understood and the role in the community was challenged. The report detailed what the new strategy ‘must’ do in order to provide a clear structure for stabilisation, recovery and transformation. These included; a
measured and sustained plan to respond to financial, operational and quality issues, reward and champion behaviour and actions that drive the delivery of the strategy and have clear outcomes which enabled active influence and contribution to the commissioner strategy.

The strategy was still in development during our inspection and was due to be presented to the Board in July 2018.

The overall priorities were aimed at

- Stabilising
- Improvement
- Transformation.

The programme of work was designed to deliver a strategy for

- Clinical and financial stability and to inform enabling strategies for IT, workforce, quality, commercial, communications, engagement and research and development.

The work was steered by executives, non-executives and the clinical director for strategy supported by a clinical reference group. The trust had conducted a series of engagement meetings with staff, patients and partners which supported alignment and ownership of the strategy and its development through the organisation and wider system.

The trust had identified a series of indicators by which the success of the strategy would be judged.

- Bringing synergy and coherence to the direction of the organisation, providing clarity to staff about their role in delivery and enabling the organisation to align
- The things that matter to the organisation, its staff, patients and partners including addressing the challenges that the organisation faces, capitalising on the opportunities for the organisation and highlighting those unique to PHT and enabling the organisation to achieve its ambition
- Supporting decision making within the organisation
- Clarity on the role for Portsmouth Hospitals NHS Trust and the contribution that it makes to: the population it serves; patients, public and staff and role in the system and with partners

Further work was being undertaken which set a clear strategic direction for the trust in the context of partnership working in the Portsmouth and South East Hampshire health and care system and the broader Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP). Strategies were in development which aligned with the STP ambition to re-align patient pathways to care by 2021.

The trust was part of the Solent Acute Alliance (SAA) (an acute service redesign to address challenging transfer arrangements between local system partners) work had already begun by clinical teams to quantify the potential changes in capacity and demand bought about by the proposals of the SAA.

There was no current estates strategy however we were told there were plans to develop one.

The trust strategy was expected to deliver a new vision and refreshed values for the organisation.
The Trust has a fortnightly recovery board to monitor the delivery of the financial recovery plan. This was chaired by the CEO and attended by the executive team, turnaround director and operational staff.

Culture
The senior team understood the importance of a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Some work had begun which addressed some immediate cultural issues and the executive team had identified further work was required to implement and sustain cultural change across the organisation. There were signs of change across the organisation and staff reported a change in approach and ‘hope’ for the future.

The executive team recognised a significant amount of work was required to improve staff culture to ensure improvements in the quality of services were sustained. They had identified an oppressive, hierarchical and permission seeking culture when they were appointed to the trust. Organisational culture had been identified as a risk on the BAF, the executive team had recognised inconsistent leadership across the trust had led to poor outcomes for patients and staff. A Listening into Action programme had been commenced which facilitated conversations with staff about areas for improvement. A cultural change programme had been implemented in early 2018. The programme was based on best practice guidelines and the use of the national toolkit (a culture and leadership programme developed by NHSI). The aim was the development of a strategy which embedded a culture that enabled continuous improvement, high quality, safe and compassionate care for patients. The trust had identified the impact of emotional wellbeing on the improvement of culture. Sessions were run which supported staff with stress management training and wellness recovery plans.

Staff we spoke with at both the core service and well led inspections recognised a change in approach by the CEO and executive team. They described the CEO as approachable and believed they had a clear focus on the improvement of patient care and listening to staff. Senior service leaders described a distinct change in approach by the executive team. They were able to challenge and felt their views were listened to.

Staff side were well engaged and had good relationships with human resources. The CEO had attended meetings twice by invitation however on both occasions there was an expectation that the new strategy would be discussed and this had not occurred. Staff side described positive relationships with the Freedom to Speak Up Guardian and the bullying and harassment steering group.

Organisational values had been developed approximately eight years ago through a series of staff focus groups. These values centred on quality of care, respect and dignity, working together and efficiency. Contribution of staff was recognised through a values based award programme. With the launch of the refreshed organisational strategy due to take place in July 2018 the trust was about to undertake a review of the values to ensure they reflected the current beliefs of staff.

The trust had a Freedom to Speak Up/Raising Concerns (whistleblowing policy) that reflected national guidance. Six whistleblowing concerns had been raised formally in the last year. As a result of one whistleblowing the trust had instigated an external review and in another case patients escalated through the whistleblowing incident were reviewed in a multidisciplinary panel. The trust had taken the concerns seriously and had investigated appropriately.

There was a Freedom to Speak Up Guardian (FTSUG) in place, recruited in line with national best practice and supported by a team of 19 Speak Up Advocates. The Guardian had direct
access to the Chief Executive, Chair and Board, and met the Chief Executive and Director of Integrated Governance on a monthly basis. There was a communication and education strategy in place with raising concerns forming a part of induction and annual update training. Additional awareness sessions had been run for junior doctors and sessions for consultants were planned. There were also strong and effective working links with staff side and the chaplaincy. The Guardian was part of a local network and had links with the Guardian in a neighbouring trust. There were also links with local universities and plans to raise awareness amongst student nurses and allied health professionals. Since taking up post in January 2018 the Guardian had dealt with 21 referrals, the majority of which had involved behaviour, and respondents to a recent survey all said they would speak up again. The arrangements in place appeared effective and the post holder was well supported. Most of the staff we spoke with were aware of the FTSUG and knew how to contact the Speak Up Advocates.

**NHS Staff Survey 2017 – results better than average of acute trusts**
The trust has 19 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.20</td>
<td>3.11</td>
</tr>
<tr>
<td>KF21. Proportion believing the organisation provides equal opportunities for career progression / promotion</td>
<td>89% (Best 20% of acute trusts)</td>
<td>85%</td>
</tr>
<tr>
<td>KF29. Proportion reporting errors, near misses or incidents witnessed in last month</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.79</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.70</td>
<td>3.65</td>
</tr>
<tr>
<td>* KF17. Proportion feeling unwell due to work related stress in last 12 months</td>
<td>33% (Best 20% of acute trusts)</td>
<td>36%</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.77 (Best 20% of acute trusts)</td>
<td>3.62</td>
</tr>
<tr>
<td>* KF16. Proportion working extra hours</td>
<td>65% (Best 20% of acute trusts)</td>
<td>72%</td>
</tr>
<tr>
<td>KF7. Proportion able to contribute towards improvements at work</td>
<td>71%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.97 (Best 20% of acute trusts)</td>
<td>3.91</td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.78</td>
<td>3.72</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.56 (Best 20% of acute trusts)</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. Proportion reporting good communication between senior management and staff</td>
<td>40% (Best 20% of acute trusts)</td>
<td>33%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.85 (Best 20% of acute trusts)</td>
<td>3.74</td>
</tr>
<tr>
<td>KF3. Proportion agreeing that their role makes a difference to patients / service users</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.76</td>
<td>3.71</td>
</tr>
<tr>
<td>*KF23. Proportion experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF24. Proportion reporting most recent experience of violence</td>
<td>73% (Best 20% of acute trusts)</td>
<td>66%</td>
</tr>
<tr>
<td>KF27. Proportion reporting most recent experience of harassment, bullying or abuse</td>
<td>49% (Best 20% of acute trusts)</td>
<td>45%</td>
</tr>
</tbody>
</table>

Please note an * denotes the questions where a lower score is better.

**NHS Staff Survey 2017 – results worse than average of acute trusts**

The trust has five key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>* KF20. % experiencing discrimination at work in last 12 months</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>* KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>34% (Worst 20% of acute trusts)</td>
<td>31%</td>
</tr>
<tr>
<td>* KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>* KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>18% (Worst 20% of acute trusts)</td>
<td>15%</td>
</tr>
<tr>
<td>* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>31% (Worst 20% of acute trusts)</td>
<td>28%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)
Staff Diversity

The trust provided ethnicity data for all staff groups at the trust. The table below displays medical, dental and nursing and midwifery staff by Ethnic group. Percentages presented are a proportion of all staff working at the trust as a whole, therefore the percentages presented do not add up to 100%.

The remaining staff not included in the table below are healthcare scientists, estates and ancillary staff, additional professional scientific and technical staff, additional clinical services staff, administrative and clerical staff and allied health professionals.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9.85%</td>
<td>25.87%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.34%</td>
<td>0.28%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.60%</td>
<td>3.55%</td>
</tr>
<tr>
<td>Black</td>
<td>0.46%</td>
<td>0.59%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.36%</td>
<td>0.10%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.28%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

For both staff groups the majority of staff identify as white, with Asian the second largest ethnicity group for both.

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
Of the four questions above, all showed a statistically significant difference in score between white and BME staff.

(Source: NHS Staff Survey 2017)

The trust did not have anyone from a BME background on the Board. They planned further recruitment of a clinically qualified non-executive director (NED) and a further associate NED and hoped the BME profile would be improved in the course of doing so.

A 2017 WRES report (July 2017) indicated that the likelihood of white staff being appointed from shortlisting was 1.18 times greater than BME staff. The relative likelihood of BME staff entering the formal disciplinary process was 1.07 greater than white staff. White staff were 0.68 times more likely to access non-mandatory training than BME staff. 78% of BME staff felt the trust provided equal opportunities for career progression compared to 91% of white staff.

The trust Equality Delivery system (EDs2) and workforce race equality standard (WRES) strategy 2014-2018 had set four equality objectives

- Better health outcomes for all
- Improved patient access and experience
- Empowered engaged well supported staff
- Inclusive leadership at all levels.

To meet these objectives the WRES strategy identified sustained, systematic inclusive leadership was required. This included equality and diversity training, engaging and communicating with staff and the strengthening of governance to ensure equality and diversity considerations were embedded in decision making processes. Actions taken as a result of the 2017 WRES report were linked to the strategy to ensure areas for improvement were identified and actioned.

During our inspection a review of the strategy was being undertaken. The strategy was due to be renamed the equality, diversity and inclusion strategy. In the trust Board papers for April 2018 we read the refreshed strategy was due to be presented and ratified at the workforce and organisational development committee in spring 2018. The strategy was planned to include an integrated improvement plan with key indicators, targets and timeframes for completion. A WRES improvement plan for 2018/19 was also included in the trust board papers.

The trust had recently re-launched its Black Asian Minority Ethnic (BAME) network. A network chair had been appointed and had been given the full support of the CEO to develop the network further. The re-launch was attended by the CEO and external speakers. The relaunch was well attended and one member of staff felt the meeting was “a safe place” to talk about their experience of working at the trust.

In discussions with BAME staff told us there had been significant changes since the arrival of the new executive team. We heard they were more able to speak up and felt listened to. Staff told us there were plans to implement a development programme for BAME staff, this had been devised to ensure BAME staff had access to develop skills that enabled career development. Staff told us there were plans to train BAME staff to attend interviews to assess unconscious bias and discrimination and report back findings to the inclusion lead. Further training would be offered to interviewers if any evidence of discrimination had been identified. We were told they felt the CEO had a vision and they felt part of that vision.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.
The trust performed similar to the England average for recommending the trust as a place to receive care from December 2016 to November 2017.

(Source: Friends and Family Test)

The feedback from patient surveys and the Friends and Families test was generally positive. Duty of candour was applied appropriately across the organisation and most of the staff had understanding of how and why it was applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We reviewed a random sample of incidents and saw that duty of candour had been applied appropriately. The CEO and chief nurse were proactive in promoting duty of candour and preferred if possible to always meet with patients and families who had been involved in incidents in the trust.

Sickness absence rates
The trust’s sickness absence rate from September 2016 to July 2017 was generally lower than the England average, aside from January 2017 and April 2017 where the trust’s sickness absence rates increased to in line with the England average.
In the 2016 General Medical Council National Training Scheme Survey the trust performed the same as expected for all 14 indicators.

(Source: General Medical Council National Training Scheme Survey)

The guardian of safe working hours was appointed in September 2016 to support junior doctors and provide assurance that junior doctors were working safely. They supported junior doctors with rota issues and educational support. The guardian had identified there was low exception reporting within the trust and they had found that training for exception reporting was lacking and further work was required to ensure foundation trainees reported exceptions to their work pattern. We spoke with 10 junior doctors who reported a positive culture with regards to safe working hours and exception reporting. They told us they were not discouraged from reporting extra hours worked.

The trust had appointed two chief registrars and part of their role was the improvement of junior doctors’ working lives and morale. The chief registrar scheme was developed by the Royal College of Physicians as a key recommendation of the Future Hospital Commission report. The
registrars had undertaken a gap analysis of the eight high impact actions identified by NHS improvement that needed to be taken to improve the working lives of junior doctors. In order to meet these ‘actions’ they had undertaken a significant body of work which supported junior doctors. This included a monthly junior doctors’ forum and monthly newsletter, acting as a conduit between junior doctors and senior management and support for raising concerns and building confidence. The registrars were near the end of their contract which was part funded by an external organisation. The trust had agreed to extend the scheme however this was to be fully funded by the trust and therefore only one chief registrar would be appointed. The executive team and the junior doctors we spoke with were very positive about the impact the chief registrars had had, not only for junior doctors but for the patient safety initiatives they had developed. There was concern from junior doctors that one chief registrar may not have the same impact and the support for junior doctors may diminish.

**Governance**

The governance systems in place did not provide a systematic governance structure which gave clear responsibilities, roles and systems of accountability. However the executive team had identified that the structure was not appropriate to meet the needs of the trust and a significant programme of work was being undertaken to revise the governance structure and strengthen its effectiveness. Some changes in governance processes had been implemented which provided greater assurance however, they would not all be fully implemented until the new organisational structure was in place.

The shortfalls in governance processes were highlighted in our reports published between 2016 – 2017. Our report published in August 2017 identified the Trust must review the governance functions and processes for the trust to ensure they were fit for purpose.

The trust governance and quality committee was chaired by a non-executive director. During our inspection the trust had 11 clinical service centres (CSC) each CSC held monthly governance meetings and reported on a rolling basis to the governance and quality committee. Monthly quality metrics were reported to the board as part of the integrated performance report and a quarterly report was presented to the governance and quality committee with key exceptions reported to the Board as required. The April 2018 Board papers demonstrated the concerns from non –executive directors that a culture of non- compliance was evident in some areas of the performance reporting, for example dementia screening. The CEO had acknowledged the current governance arrangements did not fully support oversight or accountability across the trust.

During our core service inspection we found the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not consistently applied according to the Regulations. This had been a consistent area of concern during our previous inspections and after our inspection in May 2017 we issued the trust with conditions on their registration that related to MCA and DoLS. The trust had undertaken some audits which assessed compliance, however we found knowledge had not been fully embedded, governance arrangements were not robust and documentation had not been completed in accordance with the regulations. At this inspection we have issued a warning notice under section 29A of the Health and Social Care Act 2008 asking the trust to make significant improvements to ensure MCA and DoLS are correctly applied to all patients.

We found in the medical clinical service centre staff did not consistently maintain accurate, complete and contemporaneous records of care and treatment provided to patients. Documentation was poor and the majority of records we reviewed were not individualised to patients. There had been no significant improvement in record keeping since our last inspection. At this inspection we have issued a warning notice under section 29A of the Health and Social
Care Act 2008 asking the trust to make significant improvements to the completion of patient records.

The independent review into serious incident investigation identified a lack of clinical governance within the CSCs. Each CSC had a governance lead that was responsible for supporting the lead investigator. The trust had no patient safety team to co-ordinate serious incident investigations. The trust had recognised the weakness in the governance process and the risk management department were co-ordinating the serious incident process. The trust implemented a ‘senior safety team’ who led some key areas of investigation through multi-disciplinary working groups. However this was not sustainable given the senior safety team members had their own portfolios.

The trust had recently appointed a director of integrated governance and a full governance review had been commenced. This included board reporting and a full review of the committee structures with a plan to ensure more effective ward to board understanding and oversight of issues, risks and performance. The governance review had not been finalised at the time of our inspection.

A revised governance structure had been developed which aligned to the proposed move from 11 CSC to four divisions. The aim was to provide clinically led, governance ‘friendly’ structures with standardised agendas within each division.

The proposed governance arrangements included a range of performance and accountability meetings for each division. There were plans for four executive led committees (these were still be agreed at the time of our inspection) which included integrated improvement board, senior management team, executive management team and strategy development group. Six NED led committees had been proposed which included appointments and remuneration, charitable funds, audit, finance and investment, quality and performance and workforce and organisational performance. Further sub-committees were being finalised. Executives and non –executive directors were clear about their areas of responsibility and had the agility to adapt their portfolios to suit their specific skills.

The governance of the different medicines committees in the trust had been a concern. There were plans for the Formulary and Medicines Group and the Medicines Safety Committee to jointly report to the Quality and Performance Group which would give suitable Board oversight; however this was not in place at the time of the inspection.

The trust board met regularly and provided an opportunity for scrutiny by members of the public as well as internally. The board met in two parts the first being public and the second being private. At the beginning of each board meeting there was a patient or staff story. The story of a patient’s experience of care was told and the board discussed the learning from this. The addition of the patient or staff story was felt by all in attendance to be a powerful session. The executive team told us that the addition of the stories was essential in ensuring the “patient is at the centre of what we do”. We attended both a private and public trust board meeting and found the meetings were effectively chaired and included robust challenge from members of the board. The public board meeting includes an update from the Director of Finance. The financial information received by the Board includes a balance of Board and divisional level and covers both actual and future-looking projections. Before the meeting concluded a reflection session was held. This enabled improvement and further development of the meetings.

We reviewed a number of full sets of board minutes, agendas and associated papers. There was a consistent approach to the papers presented. There were standard documents each month and a range of papers that were presented at longer intervals or required urgent consideration. The papers were of good quality and contained sufficient information which provided board assurance.
Management of risk, issues and performance
The trust was in the process of developing effective systems for identifying, assessing and planning to eliminate or reduce risks. Improvements were required to ensure serious incidents were investigated appropriately and learning disseminated. Financial challenges were starting to be managed but the trust financial position remained a risk

The trust provided their Board Assurance Framework, which details five corporate priorities and accompanying risks. A summary of these is below.

- Deliver safe, high quality, patient centred care
- Continually improve the patient experience
- Ensure delivery of national constitutional standards
- Create a healthy organisational culture where staff report they are well led and have high levels of satisfaction working in the trust
- Achieve financial health and sustainability

(Source: Trust Board Assurance Framework – P113 RPIR submission)

The executive team had identified the existing Board Assurance Framework (BAF) was not fit for purpose and the Board did not have consistent oversight of the risks in the Trust. A new BAF was developed and first presented to the Board in October 2017. The BAF was appropriate to allow the Board to record and oversee the management of risks and measure progress against strategic objectives and priorities. The information included in the BAF was appropriate and set out causes of risk, controls, assurance and ownership. The integrated performance report was used alongside the BAF and used together to provide board assurance The BAF was linked to the inherited strategy and was due to be refreshed once the new strategy had been launched in July 2018.

The trust’s risk management arrangements were under review and a new risk management strategy/policy was due to be presented to Board in April 2018. However, this was postponed to allow for the strategy to be refreshed to reflect the revised organisational structure due to take place in July 2018. The trust planned to undertake significant organisational change moving from 11 clinical service centres (CSC) to four divisions. Part of this planned change was to streamline and strengthen quality and performance monitoring. This was due to take place in July 2018.

The Board had acknowledged that the current iteration of the risk management strategy did not meet the trust’s needs and as an interim measure the Board had recently adopted a new corporate risk register (risks scoring 16 and above after review) . The ongoing review work was due to include detailed consideration of all risks at all grades that are currently on the risk registers.

Enhanced training in risk management was due to be delivered during 2018 to ensure all parts of the organisation had a better understanding of risk and the importance of effective risk management.

Board Assurance Framework
The trust provided a document detailing their 20 highest profile risks, of these 11 had a current risk score of 15 or higher at the end of Q2 2017/18, details of which can be seen below:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk Summary</th>
<th>Risk score (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF1</td>
<td>Urgent Care, Quality, Performance and Patient flow</td>
<td>20</td>
</tr>
</tbody>
</table>
BAF2 The Trust’s ICT systems do not provide adequate support for delivery of Trust objectives 20

BAF3 There is a lack of attention to basic, compassionate care in some parts of the Trust 16

BAF4 The Trust’s organisational and clinical strategies are poorly defined 16

BAF5 Organisational culture does not support efficient, effective operation 16

BAF6 Take up of mandatory and other important training is below target 16

BAF7 Some key external partnerships / collaborations fail to provide support for and/or obstruct delivery of the Trust’s objectives and priorities 16

BAF8 Demand for capital spending in the Trust exceeds capital sums available 16

BAF9 Demand for radiology services exceeds radiological capacity 15

BAF10 Demand for mental health services in the Trust exceeds mental health resource available (capacity and quality) 15

BAF11 There is insufficient evidence that the Trust’s emergency preparedness, response and resilience plans are adequate and embedded 15

(Source: Trust Corporate Risk Register / Board assurance framework P113)

The trust submitted service level risk registers and the new proposed corporate risk register in March 2018. There were 11 CSC each with their own risk registers. These contained a proportionate amount of risks for each service however some risks had been placed on the registers some time ago. The proposed corporate risk register contained 16 organisational risks aligned to the CSC risk registers some of which were also documented on the BAF. The executive management team currently meets with the leaders of each of the 11 CSC to discuss performance and accountability.

Significant changes to the monitoring of quality, risk and performance were planned to align with the proposed organisational re-structuring. After the move to four divisions the plan was to present divisional risk registers to the quality and performance committee. This would enable all risk registers to be reviewed and to inform the corporate risk register. Other quality indicators such as complaints and incidents would also be included for review at this committee.

The quality and performance committee met monthly and there was a planned programme of work which was to be undertaken over the year. Each division would be required to present quarterly risk registers, monthly reviews of quality improvement plans and quarterly quality reports.

Integrated performance reports were reported to the board on a monthly basis. These reports included performance against corporate objectives and quality, operational and financial performance. We reviewed the reports for January and February 2018 and found they provided sufficient information to assess performance.

Trust wide clinical audits of national requirements occurred and were co-ordinated and overseen by a dedicated team. Changes to national guidance were highlighted to the relevant clinicians and audits were undertaken if appropriate to ensure compliance. The clinical audit strategy included an action plan which included the prioritisation of NICE guidance and the maintenance of an audit programme that reflected organisational need based upon the national clinical audit programme.
The trust had processes in place to report, investigate and learn from incidents. Improvements to the serious incidents review process had begun with plans for improvements in the future. Further training with regards to the grading of risk was planned and an external review had been conducted. The review identified significant improvements were required to strengthen the serious incident review process. These included review and update of all relevant policies, and review of the scale and scope of serious investigation management. The report identified inconsistencies in practice, unnecessary debate and disagreement and inadequate support to the investigation leader. There was lack of focus on shared learning and executives were not involved early enough to influence investigation or improvement.

The trust had recently seen a positive increase in incident reporting although there was still work required to ensure all of the staff reported all of the incidents. Recent serious risks had triggered external review for example in the stand alone maternity departments. The reviews were taken seriously and learning was shared both internally and externally with system partners.

The trust had reported 10 never events since July 2016. Four never events had occurred in theatres (one retained equipment, two wrong site surgery and one near miss wrong site surgery) and two in obstetric theatres (one retained swab and one retained port tubing) Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

While we were assured that the never events had been reported, investigated in a thorough and timely way and learning was shared, they had continued to happen. This suggested that the learning from these never events was not sufficient, shared widely enough or the learning was not embedded, to impact on the trust’s safety performance in this area.

Risk register entries for the pharmacy and medicines optimisation were appropriately logged, escalated and acted upon. Where a direct solution could not be achieved some mitigation measures were applied.

The Audit and Finance & Performance committees have clear terms of reference. The information discussed at Finance and Performance Committee and Board is routine financial information relating to the previous month. The Trust’s financial position is reviewed at the monthly Finance and Performance Committee and the Board. There are established, regular processes for finance staff to review financial performance. In addition a Financial Recovery Board is in place which oversees the implementation of the financial recovery plan.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Previous Financial Year</th>
<th>Last Financial Year</th>
<th>This Financial Year</th>
<th>Next Financial Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£504.6m</td>
<td>£530.4m</td>
<td>£533m</td>
<td>£577.3m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£23.5m)</td>
<td>(£17.6m)</td>
<td>(£36.8m)</td>
<td>(£29.9m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£530.9m</td>
<td>£551.2m</td>
<td>£570.5m</td>
<td>£562.8m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£494.9m</td>
<td>£547.1m</td>
<td>£556.9m</td>
<td>£562.8m</td>
</tr>
</tbody>
</table>
The trust provided this commentary to provide context

The trust has been heavily financially challenged with a deteriorating financial position over the previous 5 years. A comprehensive assessment of the baseline financial position was undertaken by the Trust and presented to NHS Improvement in November 2017 and an independent assessment confirming this position was carried out by Deloitte in December 2017. Significant factors impacting the trust's adverse financial position relate to a number of structural issues for example the excess cost of the PFI, system drivers, excess capacity, and premium rate staffing costs. In addition, the NHSI Financial Investigation carried out between July and November 2017 identified a number of cultural, organisational and leadership factors which were identified as contributors to the adverse financial position. Alongside the detailed assessment of the financial position, the trust has set out the steps it is taking in relation to all these factors and the recommendations of the NHSI investigation and has incorporated this into its improvement agenda shared with NHSI on 28 November 2018. This included a significant number of actions in relation to governance and the control environment, cultural and leadership capacity and capability, and the appointment of a turnaround director combined with comprehensive delivery and strategic planning consultancy support.

Clear arrangements are in place for reporting the CIP programme. All schemes have an executive sponsor and a workstream lead. The Trust is currently implementing a revised Delivery Unit & PMO structure to manage the programme going forward.

Financial information is submitted to NHS Improvement on a monthly basis. These are discussed with the Director of Finance through the oversight arrangements at the Trust.

In M9 2017/18 the Trust revised its forecast outturn with NHSI from control total of £3.8m deficit (excluding Sustainability to Transformation Funding) to a deficit of £38.4m. The Trust delivered the revised forecast position.

The Trust’s financial plan and position are communicated to frontline staff. The planning process for 2018/19 included a number of CIP development days which enabled staff to be involved in the development of the CIP programme. All CIPs must go through a Quality Impact Assessment process including sign off by the medical director and chief nurse. The Trust is engaging with NHS Improvement’s Operational Productivity directorate to identify efficiency savings. Operational Productivity staff attended some of the CIP development days as part of the 2018/19 planning process.

The finance function has a clear plan for improving financial management processes and engages with operational management at all levels within the organisation.

Finance partners are embedded within operational teams to ensure that they receive the required financial management support and guidance and there are established, regular processes for finance staff to review financial performance.
Information management

The trust did not routinely collect, manage and use information well to support all its activities. There had been a historic under investment and lack of clarity with regards to the trust strategy. Data assurance with regards to the non 18 week waiting lists was inadequate.

Information management had been recorded as a risk on the board assurance framework. There had been a historic lack of investment in IT and a focus on tactical developments to need immediate needs rather than strategic plans. Lack of clarity around the trust strategy with regards to IT investment had compounded the risk. The trust’s IT systems and information reporting did not provide adequate support for the delivery of the proposed strategic objectives. This had led to a reduced ability to

- Produce and deliver timely and accurate diagnosis and treatment
- Monitor and react to patients conditions safely
- Support improved patient management processes
- Manage and monitor the timely allocation of resources.

The board assurance framework provided some positive assurance with regards to how this risk was mitigated. For example 97.8% of incidents had been resolved within SLA target times, additional funds and been received from NHS Digital to replace some devices and malicious web sites and computer viruses were being detected. However, the additional requirements of cyber security and operational IT support had reduced IT development capacity so some projects had to be put on hold. The IT capital funding programme for 18/19 appeared to be inadequate to address the backlog to make the IT infrastructure safe and robust or deliver digital enabled change. The trust performed poorly in the digital maturity index with respect to electronic patient records which was a direct impact of lack of investment and failure to implement the IT strategy. Plans were underway to revise the IM&T strategy to underpin the trust strategy with a five year investment plan.

There was a dedicated IT system for the emergency department (ED) however the system did not flow through to the rest of the trust. When patients were discharged from ED the records had to be printed out to take to the ward which impacted on patient flow through the department. The head of information services told us there were 70 to 110 independent IT systems within the trust belonging to clinicians or clinical areas. There had been a reoccurring theme of incidents which reported multiple patient records which related to the amount of systems used.

The director of integrated governance had been appointed as the trust senior information risk owner (SIRO) in March 2018. They had previous experience of the role and had done additional training online via NHS Digital. Information Asset owners (IAO) had been created throughout the trust after a lack of resource had been identified. They had plans to undertake reviews of the General Data Protection Regulation (GDPR) and the information governance toolkit. There had been six information governance incidents to April 2018, five of which had been reported to the Information Commissioners Office for further action. The SIRO had identified further work was required to improve information storage on the wards and clinical areas. During our inspection we found systemic evidence of poor storage of records in many of the areas we visited. Patients' records were left unsecured, unlocked records trolleys were left in public areas and computer screens which displayed patient identifiable information were left open. The security of records had been raised as a concern in our previous inspections. At this inspection we have issued a
warning notice under section 29A of the Health and Social Care Act 2008 asking the trust to make significant improvements to ensure all patients records are stored securely.

Data integrity in non-18 week waiting lists was included as a risk on the BAF. The trust had identified that there were inconsistencies in the application of the trust access policy. The development of local systems had led to inadequate assurance of the integrity of data in a number of non-18 week waiting lists. A review of the non-18 week patients seen in February and March 2018 indicated 99.18% of patients had an identified outcome (seen, treated or discharged). However 23,000 people were not on any current waiting list although some of the data was extremely old and included information from the 1930s. The Trust had identified an urgent review was to be commissioned with a focus on gastrology, audiology and ophthalmology.

Engagement

Since the arrival of the CEO the trust had collaborated much more effectively with partner organisations and staff to plan and manage appropriate services. Engagement with the public had developed however there was no co-production of current services to impact on the quality, delivery and service improvement.

The CEO had committed to meet with as many staff as possible during their first 100 days in post. This took the form of ‘big conversations’ hosted by the CEO, further formal and informal drop-in meetings and visits to clinical areas across the trust. All of the staff we spoke with during our core service and well led inspection spoke positively about the CEO. They felt the CEO had a commitment to meeting as many staff as possible, they were approachable and listened to them.

The CEO had recognised the importance of staff engagement to ensure successful and sustained delivery of the quality improvement plan. A series of engagement events had been held to inform the content of the plan as well as the identification of what mattered to staff.

We had identified in previous inspections staff were concerned about bullying and harassment in some services in the trust. The CEO and executive team showed a commitment to addressing these concerns. They were conducting a ‘deep dive’ which included staff focus groups and the completion of the medical engagement scale which would inform both immediate and long term actions.

The Listening into Action methodology was used to ensure staff were able to have a voice and were given permission to make changes happen in their area of work.

In the NHS Staff Survey 2017 the staff engagement score was 3.83 which was above the NHS trust national average of 3.79. *(Source NHS Staff Survey 2017)*

The NHS friends and family test is also completed by staff. The percentage of staff that would recommend this trust as a place to work in Q2 17/18 was 51% and had decreased compared to the same time last year when it was 68%. The percentage of staff that would recommend this trust as a place to receive care was 77% in Q2 17/18 and had decreased compared to the same time last year when it was 85%. The response rate has also decreased from 13.4% in Q2 16/17 to 0.6% in Q2 17/18.

System partners told us their relationship with the trust had improved considerably since the arrival of the CEO and the senior team. There was improved partnership working at executive level and stakeholders told us the conversations had developed a maturity which involved robust challenge
and a system wide desire to improve services for patients across the Portsmouth area. Commissioners told us the trust was now more open and transparent. They had recently been invited to sit on a variety of groups and panels; governance group, SIRI panels, clinical effectiveness group, Infection prevention and control group and safeguarding. As a result of attending these meetings there were able to gain assurance about trust performance.

The trust was developing its engagement with patient and community groups. This included face to face meetings and the use of social media. The dementia steering group included representatives from the Alzheimer’s Society and Solent MIND. The patient, family and carer collaborative had been involved in reviewing the quality improvement programme and had volunteered to work with staff to improve patient care. The ‘get involved’ strategy for 2017-2020 set four key goals

- We will continue to put the person at the centre of everything we do, ensuring that experience improvements are based on what really matters to patients, families and carers
- We will further improve the engagement and involvement of people from seldom heard groups.
- We will promote and improve face to face communication.
- We will aim to embed the patient voice in all learning and development activities.

The trust had developed different opportunities for people to become involved and had moved away from a weekly commitment to a flexible way of working. The trust had a commitment to deliver services that had been designed and developed with patients however this was in its infancy and there was no evidence that current services had been developed in co-production with patients, families, and carers.

**Learning, continuous improvement and innovation**

There was evidence of learning and reflective practices across the trust. An improvement plan had been contributed to by staff across the trust although there was identified non-compliance in some of the clinical service centres. Learning was shared from mortality reviews and trust had invested time and resource into the development of quality improvement methodologies.

Hospital Standardised Mortality Ratio (HSMR) had been rising for the previous two years. However in the six months prior to our inspection it had fallen. A monthly mortality steering group had been developed in response to the previous deterioration in HSMR to focus on all opportunities to improve learning from mortality; which provided scrutiny of all aspects of how the trust learned from deaths.

The trust had an established mortality review panel, which was held every weekday. The panel reviewed all adult (non-maternity) in-patient deaths which had occurred within the previous 48 hours. A mortality review tool was used to create an electronic record of the conclusions of the panel, and learning points were summarised. Clinicians independent of the speciality used the structured tool which aided their discussions. The case reviews included an initial assessment of potential avoidability, and the identification of areas of concern or opportunities for learning that may require further investigation. The electronic record was shared for discussion in local mortality and morbidity meetings. We found the mortality review panel to be an open, transparent, collaborative and blame-free environment and was led by credible consultants who were trained in the process.

Junior doctors reported that they found the mortality review panel was a useful opportunity to reflect on aspects of good care delivered, potential opportunities for improving care, and personal and team learning. We observed plaudits shared for an individualised care plan which included discussion around earlier opportunities for advanced care planning, appropriateness of hospital
admission and discussion around the appropriateness of planned investigations in the palliative setting.

The chief nurse was leading on the Quality Improvement Plan (QIP). The development of the plan was in two phases, the first phase was developed to address the enforcement actions that had arisen after the CQC inspections undertaken in 2017. Phase one was published in September 2017. Phase two had been developed in collaboration with frontline staff and system partners and was published in October 2017. The plan was structured in a way that was meaningful for staff and was broken into programmes; valuing the basics, supporting vulnerability in patients, organisation that learns, moving beyond safe and leading through well through good governance. There was executive sponsorship for each programme and a range of delivery work streams and nominated operational leads which supported each programme. Performance against the QIP was monitored through the monthly quality and performance committee and presented at monthly Board meetings. A dashboard of key indicators had been produced which monitored the impact of compliance with the QIP. During May 2018 two items had been achieved and removed from the plan; in addition to other actions completed in previous months. However the trust identified further work was required and planned to achieve milestones in some areas which included in dementia screening, mandatory training, safe storage of records, medicines management and complaints.

The trust was developing the Portsmouth Improvement Academy to provide training on key improvement methodologies and skills to ensure improvement was successful. Staff were being trained to deliver the Quality, Service, improvement and Redesign programme which was due to be rolled out in June 2018. In the interim an introduction to improvement training had been developed and was available to staff through an eLearning package. A series of quality improvement (QI) events had been held which had been well attended. There were plans to assess the level of QI skills across the organisation however these were still in their infancy. A QI café had been opened for staff to gain advice and support for a range of projects. The QI leads told us there was a strong appetite for change and staff were engaged and increasing in confidence.

The research department were committed to the delivery of the National Institute of Health (NIHR) funded research.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>99%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>47%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Number of complaints resolved without formal process in the last 12 months? | 5,870 | N/A

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust
The trust received 623 complaints from January 2017 to December 2017. Medicine core service received the most complaints with 240.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>240</td>
<td>38.5%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>117</td>
<td>18.8%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>101</td>
<td>16.2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>43</td>
<td>6.9%</td>
</tr>
<tr>
<td>Maternity</td>
<td>31</td>
<td>5.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>26</td>
<td>4.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>24</td>
<td>3.9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>15</td>
<td>2.4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>14</td>
<td>2.2%</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>1.8%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

There was a policy for the management of complaints, concerns, comments and compliments which had been ratified in July 2017. The policy made reference to Duty of Candour and included visual diagrams for staff to follow if a complaint had been raised. Complaints were included in the monthly quality report submitted to the governance and quality committee and complaints data was included in the integrated performance report presented to Board. We heard that since arriving at the trust the CEO had changed the style of responses and had taken responsibility for signing and reviewing each complaints response.

We reviewed a random sample of five complaints. There was evidence that complaints responses had improved and they were apologetic, compassionate and sincere. The trust produced an annual report which was presented to Board for oversight and scrutiny. Complaints themes were identified, the top three were cancelled appointments, clinical treatment and communication around care and discharge. The Trust complaints performance was poor, only 50% of complaints were responded to within the 30 day KPI. Training had been identified for staff and a complaints workshop was planned for June 2018.

Across most of the CSC we found that learning from complaints was documented and identified learning shared trust- wide. However we found lack of consistency in the CSC that delivered medical services. Only two CSC detailed any actions or learning identified after the investigation of complaints.
**Compliments**
From December 2016 to January 2017 the trust received a total of 7,767 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>2,203</td>
<td>28%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>2,033</td>
<td>26%</td>
</tr>
<tr>
<td>Maternity</td>
<td>1,536</td>
<td>20%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>936</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>743</td>
<td>10%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>203</td>
<td>3%</td>
</tr>
<tr>
<td>Critical care</td>
<td>113</td>
<td>1%</td>
</tr>
</tbody>
</table>

Please note that the trust mapped their “women and children” unit under the maternity core service, it is therefore possible that the figure for maternity above could include compliments which relate to services for children and young people and gynaecology.

(Source: **Routine Provider Information Request (RPIR) – Compliments**)

**Accreditations**
NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Accreditation and it’s successor Medical Laboratories ISO 15189</td>
<td>Clinical Microbiology, CPA accredited (Ref:0989 May 2014) Cellular Pathology including Diagnostic Cytology, Cervical Cytology including HPV testing, Histology (all areas), Mortuary (Reception, body storage and release) and Breast Sentinel Node Assay. Awarded October 2017.</td>
</tr>
<tr>
<td>Implementation of a Quality Management System across the Breast Screening Service which meets the requirements of ISO9001:2015 (accredited by BSI)</td>
<td>Breast Screening Service</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Human Tissue Authority (HTA) licence</td>
<td>The Mortuary was inspected in two one day visits in August and November 2017 and final report issued (copy available on HTA website). HTA licence number 12237 continues to be in place.</td>
</tr>
<tr>
<td>BSi certification against ISO9001:2015 standard for Radiotherapy Physics section of Medical Physics.</td>
<td>Re-certification against standard achieved 3rd August 2017, we have continually held certification against ISO9001 since Oct 1999.</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

The trust’s emergency department is located at the Queen Alexandra Hospital.

The trust also provides services at the minor injury unit at Gosport War Memorial Hospital. We did not inspect these services.

(Source: Trust Routine Provider Information Request/ Trust website)

The emergency department (ED) is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment, such as lacerations and suspected broken bones. There were 149,191 attendances from January 2017 to December 2017, of which 32,080 were children. Twenty seven percent of patients arrived by ambulance and nearly 24% of attendances were admitted to hospital.

The emergency department is a recognised trauma unit. Major trauma patients are transported directly to the nearest major trauma unit.

The department has a four-bay resuscitation area, with one bay designated for children. There are two major treatment areas; majors A has 18 bays and three cubicles, majors B has six bays and four chairs (with a trolley for clinical examination). There is a separate ‘pit stop’ assessment area with six trolleys and four chairs. In the event that the pit stop area is full, up to six patients are accommodated in the corridor while they wait for assessment. Two further corridor areas are used when the department reaches capacity.

There is a nine-bed emergency decision unit (EDU). This area comprises of two four-bed bays and a single-bed side room. The area is used for patients who are unlikely to require admission but who require short term observation or are waiting for test results. The unit is regularly used to accommodate patients with acute mental health problems who are waiting for assessment by a mental health practitioner or waiting for a mental health bed. There is a side room designated for mental health practitioners to undertake mental health assessments. The unit also accommodates frail elderly patients.

The minor treatment area has six treatment cubicles and two consultation rooms used by general practitioners to provide an urgent care service. This service operates from 8am to 11pm, seven days a week and sees patients who present with a condition which requires immediate treatment, but which can be carried out by a GP.

The emergency department has a separate children’s treatment area with its own secure waiting room. This consists of an observed play area, a high dependency cubicle, an isolation room, five major treatment cubicles and four minor treatment cubicles. This area is open from 8am until midnight, seven days a week. Outside of these hours, children are seen in the main (adult) area of the emergency department or they are taken directly to the children’s assessment unit, located elsewhere in the hospital.

We inspected this service announced and visited over three week-days. During our visit we inspected premises and equipment, observed care, spoke with staff and managers of the service and looked at patients’ records. Prior to and during the inspection we requested information from the trust which we reviewed.

The reporting period covered by this report includes an exceptionally busy winter period. The trust’s escalation status indicated that the service experienced significant and extreme operational
pressures and declared an internal critical incident on a number of occasions. This was due to increased demand and poor outflow from the hospital which resulted in high bed occupancy and insufficient inpatient capacity in the hospital. This led to extended waits and frequent crowding in the emergency department. Crowding in emergency departments is associated with an increase in mortality and impacts on patients’ experience; long waits, lack of appropriate facilities, comfort, privacy and dignity.

Activity and patient throughput
Total number of urgent and emergency care attendances at Portsmouth Hospitals NHS Trust compared to all acute trusts in England.

There were 141,651 attendances from April 2016 to March 2017 at Portsmouth Hospitals NHS Trust as indicated in the chart above.

(Source: NHS England)
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission fell from 2015/16 to 2016/17, although rates were higher than the England average. This may indicate that the service saw a higher than average proportion of acutely ill or injured patients.

(Source: NHS England)

From January to December 2017 (most recent data at time of inspection) there were 149,191 attendances, of which 32,080 were children. Patients arriving by ambulance made up 27% of the total and 24% of patients were admitted.

Urgent and Emergency Care attendances by disposal method from December 2016 to November 2017.

* Includes: no follow-up needed and follow-up treatment by GP
# Includes: left before treatment or having refused treatment
^ Includes: to A&E clinic, fracture clinic, other OP, other professional

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The service provided mandatory training in safe systems and processes but not all staff were up to date with this training. Staff told us some courses were not provided on a regular basis which made them difficult to complete. For example, ‘Conflict Resolution’ training had a completion rate of 39% for medical staff and 30% for nursing staff. Staff told us there were only a few sessions available to attend and these were usually oversubscribed.

The trust set a target of 85% for completion of all mandatory training modules, aside from information governance, which was set a target of 95%.

In urgent and emergency care, medical staff failed to meet the target, with 80% compliance overall. Registered nursing staff met the target, achieving 89% compliance overall.

A breakdown of compliance for mandatory courses for medical staff from April 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>47</td>
<td>49</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>47</td>
<td>49</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>47</td>
<td>49</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>45</td>
<td>49</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>45</td>
<td>49</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>43</td>
<td>49</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>41</td>
<td>49</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>40</td>
<td>49</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>40</td>
<td>49</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>40</td>
<td>49</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>38</td>
<td>47</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>30</td>
<td>49</td>
<td>61%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>28</td>
<td>49</td>
<td>57%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>19</td>
<td>49</td>
<td>39%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>550</strong></td>
<td><strong>684</strong></td>
<td><strong>80%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Medical staff met the target in six of the 14 modules but failed to meet the target in all other modules. Modules with the lowest compliance level included infection prevention (level 2), dementia awareness, conflict resolution and bullying and harassment awareness.

A breakdown of compliance for mandatory courses for registered nursing staff from April 2017 to January 2018 is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>175</td>
<td>176</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>175</td>
<td>176</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>174</td>
<td>176</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>173</td>
<td>176</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>173</td>
<td>176</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>172</td>
<td>142</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>136</td>
<td>142</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>167</td>
<td>142</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>135</td>
<td>176</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>167</td>
<td>176</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>126</td>
<td>176</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>161</td>
<td>176</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>119</td>
<td>142</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>106</td>
<td>142</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>114</td>
<td>174</td>
<td>66%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>43</td>
<td>142</td>
<td>30%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,316</strong></td>
<td><strong>2,610</strong></td>
<td><strong>89%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Registered nursing staff met the target in 13 of the 16 training modules, achieving 95% or over in 10 modules. Staff failed to meet the target in three modules.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew where to seek advice. Staff gave us examples of when and how they had raised safeguarding concerns and could identify the lead safeguarding nurses and how to contact them.

There were arrangements to keep both adults and children safe from abuse which were in accordance with relevant legislation. The trust’s safeguarding practice guidance and operational policy had recently been updated and brought together policies relating to adults, children and young people in one document. We reviewed this document and saw it described the definition of abuse for both adults and children who might be at risk. There was a quick reference guide for staff which gave details of how to make safeguarding referrals.

Safeguarding policies referred to relevant legislation such as the Mental Capacity Act, 2005, Care Act 2014 and Children’s Act, 1989 and 2004. These policies were accessible on the trust’s intranet pages and included contact details of the trust’s safeguarding team and external agencies.

Staff were able to identify children and adults who might be at risk of potential harm. There was a children’s safeguarding lead nurse and an adult safeguarding lead nurse within the emergency department. Staff could tell us who they were and how to contact them. However, staff in these
roles told us they did not have sufficient protected time to dedicate to the increasing responsibilities associated with these roles.

Posters about safeguarding issues were displayed in the children’s area of the emergency department. These included information about babies visiting the emergency department with bruising. The trust used the local protocol for the management of actual or suspected bruising in non-ambulant infants to identify those children at risk of potential abuse and what action to take.

There were arrangements to safeguard adults and children at risk of radicalisation, domestic abuse and Female Genital Mutilation (FGM). The trust safeguarding policy made reference to these issues and there were screening tools and referral pathways specifically for these concerns. Staff provided us with examples of when safeguarding concerns had been raised to external agencies.

Staff received effective training around safeguarding adults and children. Training was provided by the trust during staff induction and refreshed regularly. Training incorporated real life scenarios and included talks and advice from the local child abuse investigation team.

All medical and nursing staff were expected to undertake level three child protection training. At the time of the inspection 81% of medical staff and 85% of nursing staff had undertaken this training, which was below the trust target of 85%. However, the safeguarding lead told us that within the next month a further 65 staff members were expected to undertake the training, which would increase the compliance rate to the trust target.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. In urgent and emergency care, both medical and registered nursing staff met the target, with 95% and 96% compliance overall.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>49</td>
<td>49</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>48</td>
<td>49</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>47</td>
<td>49</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>22</td>
<td>27</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>166</strong></td>
<td><strong>174</strong></td>
<td><strong>95%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Medical staff met the target for three of the four safeguarding modules, but failed to meet the 85% target for level 3 safeguarding children.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for registered nursing staff in urgent and emergency care is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>175</td>
<td>176</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>174</td>
<td>176</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>140</td>
<td>142</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>113</td>
<td>133</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>602</strong></td>
<td><strong>627</strong></td>
<td><strong>96%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Registered nursing staff met the target for all four safeguarding modules.  
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

There were systems in place to control and prevent the spread of infection; however, they were not consistently complied with.

We found premises and equipment were clean and cleaners were in evidence in the emergency department throughout our visit. The department was equipped with adequate hand washing facilities and staff wore personal protective equipment, such as gloves and aprons. Staff had received mandatory training in infection control, including hand hygiene. Ninety five percent of nursing staff and 81% of medical staff were up to date with this training.

Regular hand hygiene audits were carried out. In the most recent infection prevention dashboard it was reported that the emergency department achieved 92.8% compliance in the hand hygiene audits for March and April 2018. This was graded amber as it was below the trust’s target of 95%. It was further reported that the department scored 82% (rated red) in the latest peer review hand hygiene audit (August 2017). Staff told us there was a culture in which they felt able to challenge colleagues who did not clean their hands. However, during our visit we saw some staff did not take necessary hand hygiene precautions and they were not challenged by their colleagues. We saw nurses wore protective gloves but some did not change them between patients, thereby posing the risk of spreading infection.

There were three side rooms in the emergency department where infectious patients could be isolated. However, in the most recent infection prevention dashboard (April 2018) it was reported that only 33% of patients with suspected infectious diarrhoea were correctly isolated.

We observed on one occasion that equipment (blood pressure cuffs and leads) was not cleaned between patients in the resuscitation room.

There were systems in place to ensure that clinical waste, including sharps, was appropriately segregated and disposed of. However, during our inspection we found that some sharps bins were left open. This meant there was a risk of spillage, which may cause injury or exposure to infection. Staff had to carry clinical waste, such as bedpans, through the patient seating area in the pit stop to access the sluice.

**Environment and equipment**

The design and layout of the emergency department did not keep people safe.

The layout of the department had been reconfigured over time to create more capacity but the size of the department and physical separation of the two major treatment areas did not readily allow
for good communication. Senior staff had radio contact with each other but communication remained challenging.

The emergency department was frequently crowded. During our visit we saw patients frequently queued in the corridor inside the ambulance entrance. This was a confined space and frequently became congested, hampering the movement of patients, staff and equipment. The area was not designed or equipped for patients. There were no call bells or piped oxygen and nowhere to safely secure patients’ records.

There was easy access to the co-located X-ray department and X-ray facilities were available in the resuscitation room. The CT scanning facility was not co-located and required patients to be escorted through the major treatment area.

The children’s department was co-located but physically separate, providing a secure area, which was not overlooked by adult patients and visitors. Concerns had been raised at governance and quality meetings regarding children being cared for in the adults’ department after the children’s department closed at night. This was not included on the department’s risk register.

There was a dedicated mental health assessment room located in the emergency decision unit. This did not fully comply with safety standards produced by the Royal College of Psychiatrists’ Psychiatric Liaison Accreditation Network (PLAN) because the room did not have two doors which opened both ways. However, risks were mitigated because patients did not spend time unattended in this room.

At our previous inspection in February 2017 we raised concerns that patients, assessed as being at high risk of harming themselves were not kept safe. There was a risk that patients on the emergency decision unit could abscond. The service had since installed swipe access to the unit to create a more secure environment.

The emergency department was well equipped and equipment was generally clean and well maintained. We noted however, that “I am clean stickers” available for staff to mark items as clean, were not consistently used. We found an ECG machine which was set incorrectly and recording a date of 2001. No other date or time was recorded on the ECG print out, making it invalid as a record. We reported this to a doctor who told us they would address this fault.

Assessing and responding to patient risk

Systems to assess risks to patients were not effective.

Ambulance handover

There were frequent delays in the handover of patients by ambulance staff to emergency department staff, although improvement was seen in April 2018. The emergency department was working with the ambulance service to improve the handover process.

Ambulance handovers were delayed by 30 to 60 minutes as follows: (monthly averages)

- November 2017: 64
- December 2017: 545
- January 2018: 453
- February 2018: 439
- March 2018: 513
- April 2018: 327
In the same period many patients were delayed by over an hour. This is known as a black breach. There were 339, 642 and 461, 324, 512 and 199 black breaches reported in each month respectively.

From April 2017 to March 2018 the monthly percentage of ambulance journeys with turnaround times over 30 minutes showed an increase from 32% in April 2017 to 62% in March 2018.

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Queen Alexandra Hospital**

![](image)

Staff told us that during the winter months patients were frequently held on ambulances outside the emergency department because there was no capacity to receive them in the department. This occurred for a short period on the first day of our inspection. We requested data to show how frequently this occurred but the trust was unable to provide this.

A further step, when an internal critical incident was activated, was to ‘cohort’ incoming patients, following triage, in the corridor between the minor treatment and the children’s area. We did not see this occur during our inspection. At our last inspection the trust told us this had occurred approximately 10 to 15 times from December 2017 to February 2018 but precise numbers had not been captured. We again requested data during this inspection but the trust was unable to provide this.

**Time to initial assessment**

Processes for streaming and assessing patients on arrival in the emergency department were in line with guidance issued by the Royal College of Emergency Medicine (RCEM); however at times of surge, they were not operating efficiently and assessments were sometimes delayed. RCEM recommends that systems identify the most time-critical patients for treatment and prioritise the rest.

There were streaming and triage systems in place for both ambulance-borne and self-presenting patients. Streaming is a recognised system to allocate patients to the most appropriate location and the correct person to manage their needs. Triage is a process of initial assessment which is described by RCEM as a system which sorts patients according to a combination of their presenting complaint and measured physiological parameters at the time of arrival in the emergency department.

The Royal College of Emergency Medicine recommends that patients should be assessed by a healthcare professional within 15 minutes of arrival. This standard was not consistently met, although significant improvement was seen in April 2018. In the period November 2017 to April 2018 the monthly average percentage of patients arriving by ambulance and assessed within 15 minutes was as follows:

- November 2017: 79%
- December 2017: 76%
- January 2018: 75%
- February 2018: 75%
- March 2018: 66%
- April 2018: 86%

Patients arriving by ambulance were handed over to a streaming nurse, who directed the patient to the appropriate part of the department. Patients identified as requiring assessment and treatment in the major treatment area were taken to an area known as the pit stop, located just inside the ambulance entrance. This area had six trolleys and four chairs for ambulant patients. The area was staffed by a team of nurses and healthcare support workers 24 hours a day and between 8am and 10pm there was a senior decision-maker (consultant, registrar or consultant nurse). The team was responsible for undertaking an initial assessment and ordering appropriate investigations, before streaming and moving patients to the appropriate part of the emergency department or acute medical unit ambulatory clinic. The aim was for a rapid assessment and throughput of patients, ideally within 20 minutes, in order to maintain flow in the emergency department. This system, sometimes known as rapid assessment and treatment, is also recognised by RCEM as one which improves efficiency by ensuring that patients do not wait unnecessarily for investigations or diagnostic decision making.

We observed that patients remained in the pit stop for too long, leading to a bottleneck, when there was a surge in ambulance arrivals. Some patients remained in this area for 45 minutes to an hour (the aim was to be seen in 20 minutes), while new incoming patients were assessed in the corridor. One member of staff described the process to us as “sludgy”. We raised concerns about the efficiency of this process when we visited in February 2018. It was acknowledged that the process had to become slicker.

When the pit stop was full, up to six patients could be held in the corridor area outside the pit stop. There were occasions during our inspection, when there was a surge in ambulance arrivals, and the pit stop became full but there were care spaces available in the major treatment areas. According to the Pit stop Policy, in these circumstances, additional medical and nursing staff would be identified to support the pit stop area. This was known as ‘pit stop surge’. During our inspection we observed occasions when the pit stop was full, leading to congestion in the area surrounding it. We saw the nurse in charge assisting to identify and move suitable patients to the major treatment areas.

Patients who self-presented to the emergency department were seen on arrival by a registered nurse, known as the navigator. Their role was to quickly assess patients (before they were booked in by receptionists) in order to direct them to the most appropriate area of the emergency department. This may be the minor or major treatment areas or the GP-led urgent care area.

The waiting room had been ‘divided’ by the use of red and blue floor covering to separate those patients who were waiting to be assessed, and those who had been assessed and were waiting for treatment. There was signage to direct patients on arrival to sit in the area designated ‘red’, where they would wait to be seen by the navigator. During our observation of this process we saw the signs were not sufficiently prominent. Patients and visitors were unsure what to do or where to sit when they entered the department and many went directly to the reception desk, where they were re-directed, or they asked other people in the waiting room. Following their initial assessment, patients were given a numbered ticket and asked to sit in the blue area of the waiting room where they would be called by the receptionists to register their details. They would then wait to be called by the appropriate clinician for their treatment to begin.
The navigator’s base was a glass-screened room, which enabled the nurse to observe the waiting room, although the positioning of the ‘red’ seating, just inside the entrance, meant that patients could not be easily observed by either the navigator or the reception staff. The navigator was supported by a healthcare support worker who kept an eye on the queue and frequently approached patients to greet them and direct them where to sit. This allowed them to quickly assess whether a patient required urgent attention. We observed this worked well during our observations. However, we did not see the process when the service was busy. We were told that when more than four patients were waiting to be assessed, an additional nurse would be moved from the major treatment area to support the process. This nurse was identified at handover.

Patients identified by the navigator as requiring assessment and treatment in the major treatment area were directed/escorted there immediately or, if the pit stop was full, asked to sit in one of four numbered chairs at the back of the waiting room, where they could be easily observed by staff.

We raised concerns at our last inspection in February 2018 that this process was not operating efficiently or effectively when the service was busy; this had not been audited since its introduction approximately 12 months ago and no data was available to monitor how long self-presenting patients waited to be assessed. Following our inspection, the service developed a standard operating procedure for this process. This was still in draft at the time of our inspection but we were assured that it was being implemented and there were plans to carry out weekly observations to ensure it was being followed. The service was also developing a template to capture performance data. The clinical director had undertaken a snapshot audit (nine patients arrived during one hour) on 9 April 2018, which showed that the longest wait to be seen by the navigator was eight minutes (but the navigator had spoken to and acknowledged the presence of this patient). In the integrated performance report (April) reported to the board in June 2018 it was reported that 76.2% of ‘walk in’ patients were triaged in 15 minutes.

Ongoing monitoring of risks to patients and identification of deteriorating patients

There were systems in place for the ongoing monitoring of risks to patients in the emergency department so that staff could identify seriously ill and deteriorating patients. However, we could not be assured that staff consistently adhered to these systems.

There was a serious incident in June 2017 when a patient transferred to a ward was found to be critically unstable, as a result of a failure to recognise their deterioration and failure to implement the transfer checklist/protocol. It was found that a hospital transfer from was not completed. As part of the investigation, a random sample of a further 10 transfers were reviewed and the checklist had not been completed. We asked the service if this had been audited since. The trust informed us that a transfer checklist had been developed but only recently introduced. There were plans to audit its completion as part of the documentation audit which was in development.

The emergency department used a nationally recognised ‘track and trigger’ system to identify critical illness or deteriorating patients. For patients arriving by ambulance, the receiving nurse was required to record patients’ observations, as recorded by the ambulance crew, undertake a first set of emergency department observations and calculate an early warning score. This information was recorded on a paper assessment card. We checked a number of these records and found that early warning scores were not consistently recorded.

The emergency department had introduced a safety checklist in November 2017. This was a time and sequence-based checklist of prompts and tasks, which should be completed every hour for all patients in the major treatment areas, from their first assessment to discharge or transfer to another team. It included a prompt for the identification of sepsis. The checklist had been
introduced in paper format, although there were plans for this to become an integral part of the electronic record. When we conducted a focussed inspection in February 2018 we reported extremely poor compliance with this checklist and therefore a lack of assurance that patients in the emergency department received regular checks of their safety and comfort. We questioned whether the introduction of the checklist had been managed well. The service was not regularly auditing the use of the checklist. Following our inspection, the trust told us that daily audits of the checklist had been introduced, overseen by two newly appointed matrons and reviewed by the head of nursing. There was renewed focus on the completion of the checklist and it was the responsibility of the nurse in charge of each area to prompt staff to use it. Data provided by the service showed that a sample of 15 records had been reviewed daily during April 2018. In the majority of cases a safety checklist was present, with a daily average of 82% completed. The head of nursing acknowledged that the audit was limited to reviewing completion rates and a more comprehensive audit was required to provide assurance that this risk assessment tool was being used effectively to provide assurance of safe care.

We checked a random sample of patient records during our inspection visit and found poor compliance.

- On 9 May 2018 four patients randomly selected in the area known as Majors B had no safety checklists completed.
- On 10 May 2018 we checked six safety checklists for patients in the emergency decision unit. None of these records were fully completed. Some had been commenced but had numerous gaps and others had not been started at all. In the major treatment area (A) we checked six records, all of which were incomplete. One patient, who had been in the emergency department for more than eight hours, had no checks recorded after four hours. Another patient, who had been in the emergency department for nearly 10 hours, had a gap of 5.5 hours where no checks had been recorded.

The service used a screening tool to identify suspected sepsis. There was a prompt on the paper record completed by the streaming nurse in the emergency department. This directed staff to complete the electronic-based sepsis screening and intervention tool. Similarly, the navigator was prompted to consider the possibility of sepsis in self-presenting patients and where sepsis was indicated, patients would be transferred to the major treatment area. We observed good management of sepsis in a patient receiving treatment in the resuscitation room.

Performance against standards in relation to the timely identification and treatment of sepsis in patients attending the emergency department or direct admission units in the period October 2017 to December 2017 was as follows:

- 98% of patients were screened for sepsis (against a target of 90%)
- 80% of eligible patients with sepsis were treated within one hour (against a target of 90%).

When we inspected this service in February 2017, we raised concerns about the inadequate assessment of risk and ongoing monitoring to ensure the safety of patients with mental health conditions who attend the emergency department. Since May 2017 patients attending the emergency department with acute mental illness were assessed using a mental health disturbance primary survey. This was jointly developed by the Royal College of Psychiatrists and the Royal College of Emergency Medicine for use in emergency departments. The survey, once completed, provided staff with an overall risk level and the level of observation required. The trust monitored compliance for completion of this survey and had performed at above 90% since November 2017.
The electronic patient records system had an alert function which highlighted if a patient had a pre-existing mental health condition or care plan. Staff received de-escalation training as part of mandatory conflict resolution training; however, as at April 2018 only 30% of staff had completed this. There were plans to address this shortfall in 2018. In addition, nine staff had received training in breakaway techniques.

There were clear pathways in the emergency department for patients who presented with mental health needs, to ensure that they were located in the most appropriate part of the department and, importantly ensuring they were supervised if assessed as at risk of harming themselves or absconding.

Following initial assessment some patients would wait in the minor treatment area. This area was not secure but allowed some level of observation. The emergency decision unit was commonly used to accommodate patients with mental health needs. There was a dedicated assessment room here and the ward staffing included a registered mental health nurse 24 hours a day, seven days a week. The ward had been made more secure since our last visit; doors were locked to prevent patients absconding. All exits from the department could be viewed on CCTV at the nurses’ station. However, the risk of patients absconding was still deemed to be present, especially when the department was busy. This was recorded on the emergency department risk register.

A ligature audit was carried out in the emergency decision unit in February 2017 by a member of the mental health liaison team. This identified specific ligature risks in each area of the ward and made recommendations to mitigate these risks, by for example, fixing items to the wall and providing ligature cutters. The timescale for implementing these recommendations was not stated and it was not clear if they had been actioned.

Patients were not routinely or consistently assessed for the risk of falls or developing pressure ulcers. We saw no evidence of risk assessments undertaken by nursing staff in the emergency department in relation to falls or pressure ulcers. The head of nursing told us that falls risk assessments were not undertaken. However, following the inspection we were told that falls risk assessments were completed on the electronic records system. During our inspection we heard a relative inform staff that their family member had a large sacral sore, which staff were not aware of as the patient had not been assessed for risk of damage. Once informed the staff took appropriate steps to prevent further damage.

We saw a patient in the resuscitation room had an unwitnessed seizure. Relatives alerted staff, of which three were in the vicinity but were not observing the patient.

The trust was not taking adequate steps to manage crowding in the emergency department. Despite what staff described to us as “returning to normal” after the pressures experienced during the winter months, crowding was still a regular occurrence.

There was a Full Capacity Policy (February 2018) which set out the steps to be taken to address crowding in the emergency department. The policy stated: “When the emergency department has reached its maximum number of patients (or is rapidly approaching its maximum), safety of the patients and staff is at risk. When the ED is at OPEL four escalation status, normal functioning of the department is not possible.” The OPEL (operational pressures escalation level) framework is a national system which allows operational pressures to be measured consistently by healthcare organisations, using a set of agreed definitions. The Full Capacity Protocol was activated when the trust or the emergency department’s status was at OPEL three (major pressures compromising patient flow), approaching OPEL four (organisations unable to deliver comprehensive care).
There was an escalation board in the major treatment area, displaying the escalation status of the department and the triggers to be used to instigate the full capacity protocol. We noted that the status did not change during our visit to the department, despite the fact that, at times, the department was crowded, patients queued in the corridor and were held on ambulances. The head of nursing confirmed that the escalation status was not assessed on the first day of our inspection. They assured us however that there was regular communication with the operations management team throughout the period and they were aware of the pressures being experienced in the emergency department.

**Emergency Department Survey 2016**
The trust scored “about the same” as other trusts for all five of the emergency department survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Nurse staffing**
The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, there were a significant number of registered nurse vacancies and there was heavy reliance on temporary staff to ensure that assessed and planned staff to patient ratios were consistently met.

The emergency department had recently reviewed nurse staffing numbers and skill mix to meet increasing demand and a business case for a further 10 registered nurses had recently been “agreed in principle”. The service had been employing significant numbers of temporary staff in order to meet the required (assessed) nurse to patient ratios. In March 2018 a total of 804 shifts were filled with temporary staff, while 62 remained unfilled. It was reported in January 2018 that many shifts comprised 40-50% bank or agency staff.

Staff told us that bank and agency staff employed were often regularly utilised and so were familiar with the department. There was a local induction checklist which was completed by temporary staff and records were held in the department.

In December 2017 the trust reported a turnover rate of 12.6 % for registered nursing staff in urgent and emergency care which is above the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
At the time of our inspection there were 20 whole-time equivalent nurse vacancies. The head of nursing told us there were plans to recruit approximately three nurses per quarter. This meant the emergency department would continue to rely on temporary staff for some time to come.

From December 2016 to November 2017, the trust reported an annual sickness rate of 3.8% for registered nursing staff in urgent and emergency care, which was slightly worse than the trust’s target sickness rate of 3.0%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical staffing

There was senior medical presence in the emergency department for 24 hours a day, seven days a week. Consultants were present for 16 hours a day, which is in line with the Royal College of Emergency Medicine’s recommendations. There were 2.5 whole time equivalent (WTE) consultants in paediatric emergency medicine, in addition to five dual-trained (adults and children) consultants and a specialist trainee. There was a consultant psychiatrist employed Monday to Friday.

There were continuing concerns about medical staff cover at night. Senior medical cover was provided at night by a registrar or middle grade doctor, supported by a consultant on call. This was universally felt to be inadequate. Consultants felt obliged to stay late in order to support their more junior colleagues. There was a concern about the number of additional hours being worked by seniors and lack of support for juniors. A business case for more senior medical staff had been agreed and recruitment was underway. In the meantime the service continued to try to recruit locums at night but gaps were rarely filled.

During our inspection junior doctors we spoke with did not express concerns about staffing levels and told us they felt adequately supported by senior staff. There were continuing concerns however, about the long waits to be seen at night when there was only one senior decision maker on duty.

The trust reported their staffing numbers below for medical staff in urgent and emergency care from April 2017 to March 2018.

Fill rates ranged from 81.2% to 105.5% during the period. As of March 2018, there were 4.8 fewer whole time equivalent (WTE) staff in post than the trust originally planned to provide safe and effective care.
<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>51.3</td>
<td>43.5</td>
<td>84.8%</td>
</tr>
<tr>
<td>May</td>
<td>51.3</td>
<td>43.5</td>
<td>84.8%</td>
</tr>
<tr>
<td>June</td>
<td>52.3</td>
<td>43.5</td>
<td>83.2%</td>
</tr>
<tr>
<td>July</td>
<td>52.3</td>
<td>42.5</td>
<td>81.2%</td>
</tr>
<tr>
<td>August</td>
<td>51.3</td>
<td>54.1</td>
<td>105.5%</td>
</tr>
<tr>
<td>September</td>
<td>51.6</td>
<td>50.1</td>
<td>97.1%</td>
</tr>
<tr>
<td>October</td>
<td>51.6</td>
<td>49.6</td>
<td>96.2%</td>
</tr>
<tr>
<td>November</td>
<td>51.6</td>
<td>48.6</td>
<td>94.3%</td>
</tr>
<tr>
<td>December</td>
<td>51.6</td>
<td>48.0</td>
<td>93.1%</td>
</tr>
<tr>
<td>January</td>
<td>51.6</td>
<td>48.0</td>
<td>93.1%</td>
</tr>
<tr>
<td>February</td>
<td>52.6</td>
<td>49.5</td>
<td>94.2%</td>
</tr>
<tr>
<td>March</td>
<td>52.6</td>
<td>47.7</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From January 2017 to December 2017 the trust reported an annual vacancy rate of -1.4% for medical staff in urgent and emergency care. This reflects a reported over establishment. However, this does not take into account the business case to increase the medical staff establishment.

The trust did not have a target vacancy rate but medical staff had a lower vacancy rate than the trust total for all staff groups of 7.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

In December 2017 the trust reported a turnover rate of 1.0% for medical staff in urgent and emergency care, which is below the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, the trust reported an annual sickness rate of 1.8 % for medical staff in urgent and emergency care, which is better than the trust’s target sickness rate of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
In March 218 there were eight shifts filled by temporary staff and 16 shifts unfilled at senior house officer level. There were four shifts filled by temporary staff and eight shifts unfilled at registrar level.

(Source: Data request DR355)

In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for whole time equivalent staff working in Urgent and Emergency Care at Portsmouth Hospitals NHS Trust.
Staff did not consistently keep appropriate records of patients’ care and treatment. Most of the
records we reviewed were not accurate or complete. Methods to audit record keeping were not
fully developed and the service was unable to provide assurance that record keeping standards
were complied with.

We checked a sample of initial assessment cards; most were incomplete and entries were not
signed or dated. Safety checklists, which staff were required to complete for all patients receiving
care and treatment in the major treatment areas, were not consistently completed and we saw
many examples where sections of the record were completed some considerable time
retrospectively following the check/intervention taking place. We witnessed a handover of a
patient from the pit stop to the major treatment area. The pit stop nurse had not completed a
safety checklist for the patient and the receiving nurse said they would complete it retrospectively.
This meant that records did not provide a contemporaneous account of care and treatment and
may not be accurate.

Following our inspection in February 2018 we raised concerns that the use of the safety checklist
was not embedded within the emergency department. Compliance was extremely poor and only
one snapshot audit had taken place since its introduction in November 2017. Following our
inspection, the trust told us that daily audits had commenced, overseen by two newly appointed
matrons. When we spoke with the head of nursing they told us they thought that compliance was
improving, although there was still further improvement required. The audit data supplied
supported this view. They acknowledged that the method of audit did not capture qualitative data
and was merely a “tick box exercise”.

Patients’ records were appropriately and safely stored. Records were mostly electronic, and
access to these records was password controlled. There were some paper records, which were
scanned on discharge to form part of the electronic paper record. Paper records in use were
stored in pigeon holes, accessible only to staff.

Medicines
The service prescribed, gave and recorded and stored medicines well; however, we found some
recording omissions.
Medicines, including controlled drugs were appropriately stored in secure areas. Suitable emergency medicines were available, stored appropriately and regularly checked. Medicines stored in fridges were stored at the correct temperature at the time of our visit and records confirmed that temperature checks had taken place in the first seven days of May 2018. There was evidence to show that when temperatures were found not to be in the correct range, appropriate action had been taken. However, records for previous months contained many gaps so we could not be assured that monitoring systems were effective.

Prescriptions were stored securely and there were clear records kept of their use.

Staff did not always record the dose of controlled drugs given and the amount wasted.

Appropriate Patient Group Directions (PGDs) were available for use. PGDs are agreements which allow some registered and appropriately trained nurses to supply and administer certain medicines to a pre-defined group of patients without them having to see a doctor. There was a process for reviewing PGDs to ensure they remained up to date and a member of staff had the responsibility of monitoring the need for more PGDs and liaising with clinical teams.

There was a process for identifying high risk and time-critical medicines on the patient records system when patients were booked into the emergency department. Alerts were added to patients’ records so that nurses were prompted to administer patients ongoing medicine’s while they were in the department.

A pharmacist independent prescriber had recently joined the emergency department team. They worked from Monday to Friday and had a wide brief to support patient safety. They were able to support clinicians in the department by, for example, conducting medicines reconciliation where patients needed time-critical medicines, prescribing for discharge or on admission or ensuring a course of antibiotics continued after the initial dose had been given.

Incidents

There were systems to monitor incidents, investigate them and implement learning. However, we were concerned about a number of serious incidents in the emergency department where there was an apparent lack of timely action to prevent further similar incidents. Two falls, one in November 2017 and a second one in March 2018, had resulted in patients sustaining a fractured hip. Despite this, there was no falls risk assessment tool in use in the emergency department. We asked four members of staff if there was a falls champion in the department and they could not identify anybody.

Falls were a common incident theme in the emergency department. There were eight falls reported in April 2018 and it was identified that the use of commodes was a common theme. We were told that the senior nursing team were planning to meet with the falls coordinator to discuss what falls assessment should be carried out in the emergency department and emergency decision unit.

A serious incident which occurred in June 2017 highlighted a failure to identify a deteriorating patient and failure to complete a transfer form when the patient was transferred to a ward. A further 10 transfer records were reviewed and found transfer forms had not been completed. The trust had only recently introduced a transfer checklist and its use had not been audited since introduction.

Staff were encouraged to report incidents and the emergency department had seen a significant increase in reported incidents over the last two years, with 40 to 50 incidents reported each week. This level of reporting had however resulted in a backlog of low or no harm incidents (350) that
were awaiting review. This was recorded on the department’s risk register and was regularly discussed at governance and quality meetings. The emergency department had developed guidance for staff, which included a list of incidents which should be reported. Staff told us they knew how to report incidents and they received feedback when they did so.

The service investigated incidents and shared learning with staff. A monthly emergency department governance newsletter, emailed to all staff and displayed in the department, kept staff informed of recent incidents and learning from incidents. There was also an electronic link to information on how to report an incident. The April 2018 newsletter summarised the previous month’s incidents by theme and there was feedback about a number of recent incidents. These included an incident reported after a doctor took blood and left a blood stained trolley. Staff were reminded about the importance of cleaning up after themselves and challenging colleagues if they are witnessed to be displaying poor practice in this area. Other learning from incidents included advice on identifying an inguinal and femoral hernia and identifying fractured neck of femur, particularly in frail elderly patients with cognitive impairment. There was also advice on medicines storage and patient restraint, following incidents.

There were monthly mortality and morbidity meetings, where the care of patients who had complications or unexpected outcomes, was reviewed so that learning could be identified and shared. The last meeting had taken place in February 2018 and recorded the number and causes of all deaths in the emergency department in September, October, November and December 2017. Several cases were presented and discussed. Meetings scheduled for January, March and April 2018 were cancelled due to operational pressures. The lead consultant for governance (associate medical director) produced six monthly reports to the trust-wide clinical effectiveness and mortality review group.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported no incidents classified as never events in urgent and emergency care. 

(Source: NHS Improvement - STEIS)

Duty of Candour
Senior staff we spoke with demonstrated a good understanding of duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient, and to provide support when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. We reviewed a number of incidents and complaints where duty of candour had been appropriately applied.

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported 387 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from February 2017 to January 2018.

A breakdown of the incident types is shown below:

- 367 major incident/ emergency preparedness, resilience and response/ suspension of services (95%) – 364 of these incidents relate to breaches of the 12-hour DTA (Decision to admit) standard, the other three incidents relate to ambulance diverts in place due to
pressure on the emergency department.

- Five sub-optimal care of the deteriorating patient meeting SI criteria (1%)
- Five slips/trips/falls meeting SI criteria (1%)
- Three diagnostic incidents, including delay meeting SI criteria (including failure to act on test results) (1%)
- Two apparent/actual/suspected self-inflicted harm meeting SI criteria (0.5%)
- Two treatment delay meeting SI criteria (0.5%)
- One abuse/alleged abuse of child patient by third party (<0.5%)
- One abuse/alleged abuse of adult patient by staff (<0.5%)
- One pending review (<0.5%)

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)

By far the most common incident cause related to breaches of the 12-hour decision to admit standard. It was reported to the trust clinical effectiveness and mortality review committee in May 2018 that there had been a significant spike in deaths in the emergency department over the winter months (the number of deaths in December 2017 was double the number in December 2016. It was thought that a contributory factor to the excess was the time that patients waited in the department for a bed. It was reported that in the six months September 2017 to February 2018 there were at least 25 patients (15% of deaths) who died after a prolonged wait for a ward bed. The trust assured us that, following a review of all deaths in the emergency department, long waits for a bed were not a causative factor.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment in accordance with evidence-based guidance, including Royal College of Emergency Medicine (RCEM) and National Institute for Health and Care Excellence (NICE) guidelines. There was a suite of clinical guidelines, which were well organised and easily accessible on the intranet. There was a nominated consultant who was responsible for ensuring these were up to date.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs, although we saw some occasions when this was not the case or it was not documented. Patients we spoke with confirmed they had been offered food and drink and we saw staff arranging hot and cold food and drinks. The patient safety checklist, which staff were required to complete for all patients in the major treatment areas, prompted nursing staff to offer and provide food and drink on a regular basis. However, as referred to earlier in this report, checklists were not consistently completed; therefore, we could not be assured that this occurred. In many cases the relevant box on the checklist was ticked but staff had not recorded whether the patient had been given food and drink or declined it. On the emergency decision unit we heard a patient ask for breakfast, they were told they would have to wait until lunch time. A staff member found them a packet of biscuits.

A relative told us they had approached a nurse to request a drink for their family member who was a patient in the corridor. They told us the nurse had refused to leave their computer and advised the relative to find another member of staff.

The department had responded to patient concerns that food was not being provided regularly in the ‘majors’ area and that patients often missed the planned meal provision. We saw a display in the waiting area which noted that patients were now being given snack packs and soup as a result of these concerns.

There was chilled bottled water available for patients in the emergency department.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.7 out of 10 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Pain relief

In the emergency department newsletter (April 2018), it was reported that there had been a number of incidents which related to delayed pain relief. Staff were reminded that patients should have their pain assessed hourly and this should be recorded on the safety checklist. We noted on numerous records staff had marked this as N/A (not applicable); therefore, we could not be assured that patients had been regularly asked about pain.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.6 out of 10 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 8 out of 10 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.
<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Patient outcomes**

Information about clinical outcomes was collected and monitored. The trust participated in national Royal College of Emergency Medicine (RCEM) audits so they could benchmark performance against best practice and other emergency departments. Performance was mixed (see below).

Audit summary reports were produced, with action plans. There was evidence that audit results had been shared with staff, and actions taken, in progress or planned. We noted however that no timescales for actions or review were recorded. There was a designated consultant lead for audit who oversaw the department’s audit programme and an audit page on the intranet. We were told that audits were discussed at regular consultant meetings, although we saw no evidence of this in meeting records provide by the department. The emergency department reported on audit results and actions at six-monthly trust clinical effectiveness meetings.

**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 Moderate and Acute Severe Asthma report, Queen Alexandra Hospital failed to meet any of the RCEM standards.

The hospital was in the lower UK quartile for two standards:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 8.7%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 63.2%; UK: 77%.

The hospital’s results for the remaining five metrics were all between the upper and lower UK quartiles.

The audit summary report and action plan (undated) was shared with us. Actions included dissemination of audit results at consultant meetings, and regular teaching. An acute asthma pathway had been jointly produced with respiratory physicians.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, Queen Alexandra Hospital failed to meet any of the standards.

The hospital was in the upper UK quartile for one standard:

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over. Hospital: 24.0%; UK: 11%.

The hospital’s results for the remaining three standards were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

The audit summary report and action plan was shared with us. Actions included dissemination of audit results at consultant meetings, the further development of the ‘pit stop’ model in the
emergency department, senior reviews being time-stamped and recorded on the recording system and a change of consultant working patterns to provide clinical presence 8am to 12.30am in both adult and paediatric areas.

**RCEM Audit: Severe sepsis and septic shock 2016/17**
In the 2016/17 severe sepsis and septic shock audit, Queen Alexandra Hospital was in the upper UK quartile for one standard:
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 69.7%; UK: 44.9%.

The hospital was in the lower UK quartile for one standard:
- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 16.8%; UK: 69.1%.

The hospital’s results for the remaining six metrics were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

The audit summary report and action plan was shared with us. Actions included the development of a training programme for the role of advanced sepsis care nurses and the strengthening of links between nursing and medical staff within the emergency department.

A consultant sepsis lead had been identified and provided updates on the action plan to the Emergency Clinical Service Centre Board in April 2018. Issues highlighted at this meeting included delays in the prescription and administration of antibiotics and the timing and scanning of initial assessment documents. However, there was an improving picture reported between January and April 2018. In January 2018 seventy-four percent of patients received antibiotics within 60 minutes of arrival in the emergency department, rising to 95% in April 2018. This was felt to be, in part, due to improved assessment within the ‘pit stop’ area.

**RCEM Audit: Vital signs in children 2015/16**
In the 2015/16 Vital signs in children audit, Queen Alexandra Hospital met the standard in three of the six measures.

The hospital was in the upper England quartile for one fundamental standard and two developmental standards:
- Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 100%; England: 69.7%.
- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 100%; England: 73.2%.
- Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Hospital: 100%; England: 60%.

The hospital was in the lower England quartile for one developmental standard:
- Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Hospital: 0.0%; England: 4.4%.
The hospital’s results for the remaining two metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

The audit summary report and action plan was shared with us. Actions included the dissemination of audit results amongst medical staff, teaching of both nursing and medical staff in the recognition of the unwell child and the paediatric early warning system, simulation training and increased and dedicated consultant presence in the emergency department.

RCEM Audit: Procedural sedation in adults 2015/16
In the 2015/16 Procedural sedation in adults audit, Queen Alexandra Hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the upper England quartile for three fundamental standards and one developmental standard:

- Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 98.6%; England: 90.0%.
- Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  - Standard 4a. A doctor as sedationist
  - Standard 4b. A second doctor, ENP or ANP as procedurist
  - Standard 4c. A nurse
    Hospital: 73.2%; England: 40.8%.
- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 91.6%; England: 41.0%.
- Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - Standard 7a. (fundamental): Return to baseline level of consciousness
  - Standard 7c. (fundamental): Absence of respiratory compromise.
  - Standard 7d. (fundamental): Absence of significant pain and discomfort.
  - Standard 7e. (developmental): Written advice on discharge for all patients.
    Hospital: 81.8%; England: 2.6%.

The hospital’s results for the remaining three metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

The audit summary and action plan was shared with us. Actions taken included the development of a procedural sedation profoma and a checklist that is completed within the computer record system. There was a planned sedation teaching programme for all users with incorporated simulation training and a regional based training passport/portfolio for staff.

Formal discharge paperwork had been developed to be given to the patient on discharge.

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16
In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit Queen Alexandra Hospital met the audit standard in one of the two measures (which were both 100%).

The hospital was in the upper England quartile for both standards:

- Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be
written evidence of the patient receiving or being referred for treatment. Hospital: 100%; England: 100%.

- Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Hospital: 92.5%; England: 2.0%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days
From March 2017 to September 2017, the trust’s unplanned re-attendance rate to ED within seven days was consistently above (worse than) the national standard of 5% and generally about the same as the England average, ranging from 7.5% to 8.3% compared to the England average range of 7.5% to 7.9%

From October 2017 to February 2018 the trust performed better than the England average with a 7.2% re-attendance rate in February 2018 compared to the England average of 7.7%.

Unplanned re-attendance rate within 7 days - Portsmouth Hospitals NHS Trust

(Source: NHS Digital - A&E quality)

Competent staff

The service provided appropriate training and support to ensure staff were competent for their roles.

There was a nurse practice educator (currently seconded to an interim matron position). They described to us a comprehensive in-house training programme for nurses and a structured approach to developing band five nurses, using a competency framework. There were eight in-house study days, which included all essential role-specific competencies, including training in use of equipment.

The practice educator told us that supervision and appraisal for nurses were quite “ad hoc” and it was recognised that a more structured approach to this was required. There were plans to develop band seven nurses to progress this.

Junior doctors received two hours of training time, which was protected each week, regardless of the pressure in the department. They told us consultants offered excellent support. We observed good informal teaching sessions led by consultants during staff handover sessions. There was multidisciplinary simulation training provided on the shop floor.
There was an advanced care practitioner programme and the department was extending the use of this role in the department.

**Appraisal rates**
From April 2017 to March 2018, only 56% of staff within urgent and emergency care had received an appraisal, which did not meet the trust target of 85%.
This is split by staff group below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Staff - Hospital</td>
<td>49</td>
<td>47</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>30</td>
<td>16</td>
<td>53%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>49</td>
<td>25</td>
<td>51%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Registered Nursing Staff</td>
<td>162</td>
<td>73</td>
<td>45%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>295</strong></td>
<td><strong>166</strong></td>
<td><strong>56%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Medical staff achieved the target, with 96% appraisal completion but registered nursing staff failed to meet the target, with 45%.
(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**
Staff, teams and services worked well to deliver effective care and treatment. Medical staff told us they felt well supported by the rest of the hospital. Most referrals from the emergency department were to the acute medical or surgical specialty teams. Medical admissions were usually via the acute medical unit (AMU) and the AMU physicians were visible in the emergency department when it was under pressure. Sub speciality advice was available but doctors told us this was usually at registrar, not consultant level.

There was an ambulatory emergency care (AEC) unit, where emergency department clinicians could refer appropriate patients, who were unlikely to require admission. The AEC consultant had access to the emergency department computer system and could identify suitable patients. They routinely attended the emergency department for the morning handover meeting where they identified suitable patients.

There was a Frailty and Interface Team (FIT) based in the emergency department. The team, who were highly regarded by emergency department staff, saw approximately 140 patients a week, assisting with the discharge of approximately 50% from the emergency department or the emergency decision unit. Patients were given a frailty score on arrival (triage) and suitable patients were either referred to the frailty team or were proactively identified by the team, who had access to the emergency department computer system, and reviewed, regardless of their location.

The frailty team consisted of geriatricians, doctors, community nurses, older persons nurse specialists, physiotherapists, occupational therapists and health care support workers. There were also links with social workers from two local authorities, mental health teams and the hospital’s dementia case workers. The team worked well and proactively with other disciplines throughout the hospital and wider community with the aim to deliver effective care and achieve better outcomes for older people.
A palliative care consultant had spent a week working with end of life patients in the emergency department. This had enabled relationships to be built and the sharing of best practice in relation to how to care for these patients within the department.

The trust had recently developed an **Acute Admissions Standard Operating Procedure**, agreed by all chiefs of service, the trust medical director and the chief executive, with a view to preventing delays in the referral process. The procedure set out the appropriate admission routes for patients with identified acute illnesses and clarified that the responsibility for the ongoing care of these patients, once referred, lay with the admitting specialty, regardless of the location of the patients. There were internal professional standards displayed in the major treatment area, which reinforced that specialty clinicians were expected to review patients in the emergency department within 60 minutes. However, this was not monitored or reported on.

Staff reported good working relationships with radiology.

**Seven-day services**

The service was working towards the provision of a full range of services seven days a week. There was access to radiology services seven days a week, with rapid access to CT scanning facilities.

The mental health liaison service was available seven days a week from 8am until midnight. Outside of these hours the local mental health crisis team was responsible for supporting the emergency department with urgent mental health assessments, although this service was not responsive.

There was access to pharmacy advice seven days a week, with a pharmacist on call out of hours.

**Health promotion**

Patients needing additional support, for example, those at risk of developing a long-term condition were sometimes identified within the emergency department. The Frailty and Interface Team proactively screened and assessed older patients who might be regarded as frail. It was hoped that fast investigation and action at the ‘front door’ could prevent adverse outcomes and help people live as well as possible.

Patients were empowered to manage their own health. Staff told us they offered advice to patients about stopping smoking and general lifestyle guidance. However, staff could not identify any formal provision for patients to access.

National priorities to improve the population’s health were sometimes supported. We saw posters displayed in the department giving information about alcohol dependency and ‘scratch cards’ given out for people to assess their own alcohol intake. There was an alcohol team available on weekdays where patients could be referred if further support was requested. However, we saw no evidence of support provided around drug misuse, obesity or cancer risks.

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

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance including the Mental Capacity Act, 2005. During our inspection we spoke with a nurse regarding the need for a capacity assessment for an older patient who was confused and did not speak English. The nurse informed us that a capacity assessment was not necessary because their relative was translating for them. There was no documented evidence that this patient had been involved in the decision to put a DNACPR in place.
Staff told us that the mental capacity of a patient was usually assessed by medical staff and documented in the patient’s notes, rather than using the formal mental capacity assessment tool. Nursing staff were not familiar with this document and generally found relevant forms difficult to find on the patient record system.

Nursing staff we spoke with told us they had received further training in mental capacity and deprivation of liberty safeguards but there was still a lack of confidence around decision making and using the guidance.

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty training. In urgent and emergency care, medical staff met the target with 90% compliance overall for the three relevant training modules. Registered nursing staff also met the target with 90% compliance overall for four relevant training modules.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>47</td>
<td>49</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>43</td>
<td>49</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>21</td>
<td>26</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for registered nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Enhanced</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>174</td>
<td>176</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>173</td>
<td>176</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>93</td>
<td>140</td>
<td>66%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14/P49)
Is the service caring?

Compassionate care

Staff did not always provide patients with compassionate care. We saw many staff in different roles interact with patients in a kind, respectful and considerate way. However, we observed a number of nursing staff who did not behave in a way which was consistent with the trust’s stated values or desired practice. We observed one nurse who was rude to a patient and to their colleagues and some nurses were hostile towards us.

Patients’ privacy and dignity were not always respected. We saw a frail and vulnerable patient get out of bed and struggle for some time to cover themselves to preserve their dignity. We were concerned they were at risk of falling. There were six staff in the vicinity (doctors, nurses and support staff) but this went unnoticed for almost five minutes until an administrative member of staff (the tracker) noticed their distress and intervened. They asked the patient to sit on the bed while they fetched a nurse. A nurse then came quickly and dealt kindly with the patient behind the cubicle curtains. Approximately five minutes later we observed the patient struggling to take a drink. Again, this was unwitnessed for some time by the numerous staff in the vicinity and no assistance was offered.

We observed a nurse starting an assessment of a patient whilst they were seated in the waiting area of the main reception in front of other patients. We saw another nurse intervene and advise their colleague to find a private room to undertake the assessment to ensure the patient’s privacy.

When patients were moved between different areas of the department we observed that some staff did not make eye contact nor introduce themselves to patients. We saw staff often ignored and spoke over patients, directing porters or ambulance staff to allocated bays, without any greeting or interaction with the patient.

Feedback from patients we spoke with during our inspection was mixed. We spoke with a number of patients who told us they received care and treatment from attentive staff. One patient told us they had always received a “wonderful service” and another stated that staff were “great” and “lovely”. However, we spoke with other patients who said they felt staff were not always considerate. One patient told us they felt they had been “forgotten about” and a relative stated that staff were too busy to make sure the patient had a blanket when they were waiting in a cold corridor.

Receptionists and nursing staff who greeted patients who self-presented to the emergency department were polite, and attentive. We observed staff welcoming these patients to the department, offering chairs and glasses of water, if needed. We saw a nurse working in the minor treatment area, enter the waiting room, call patients and introduce themselves in a friendly manner. We saw porters interacted with patients in a friendly way.

The most recent Friends and Family test results (March 2018) indicated that 94% of patients were likely or extremely likely to recommend the service. This was better than the England average of 85.5%. In the paediatric waiting area we saw comments from the friends and family test were presented in a colourful, child friendly display. We observed comments such as; “staff were careful and gentle” as well as providing a “very quick and caring service”.
Friends and Family test performance
From March 2017 to February 2018 the trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently better than the England average ranging from 93.8% (February 2018) to 96.3% (October 2017). However, it should be noted that response rates were low.

In the latest period, February 2018, the trust’s performance was 93.8% compared to the England average of 84.7%.

A&E Friends and Family Test Performance - Portsmouth Hospitals NHS Trust

(Source: NHS England Friends and Family Test)

In the period January to December 2017 twelve complaints had been received which related to attitude and behaviour of staff.

Emotional support

Staff did not always provide emotional support to patients and relatives to minimise their distress. We observed a nurse raising their voice and being openly angry and threatening towards a patient who was attempting to leave the department. This was in front of other patients. The nurse did not de-escalate the situation and appeared to cause more distress. We raised this with the head of nursing in the emergency department at the time of the inspection.

We saw a family becoming very distressed whilst their relative was receiving treatment in the resuscitation room. Staff had not explained to the family the purpose of the procedure taking place or how it would affect their relative. This resulted in them leaving the room in a distressed state. No staff member followed the family to ensure they were supported. A member of the inspection team had to intervene and the family were eventually assisted by a consultant who we observed acted with sensitivity and consideration.

We saw a patient crying and agitated with pain. We observed numerous members of staff walking by this patient without attempting to intervene for approximately one hour. A member of the inspection team raised this at the time of the inspection and pain relief was only then prescribed.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in England in all questions relating to caring. One of the lowest scores in relation to caring was the question, “if you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you”? Patients scored the trust 6.5 out of 10 for this question.
Within the paediatric waiting area we saw evidence of positive feedback from parents received from the friends and family test. This included one comment relating to how well staff had distracted their child during a painful procedure, through the use of bubbles and building blocks. There were further comments that staff were supportive to parents while their child was being treated.

Understanding and involvement of patients and those close to them

Staff did not always involve patients and those close to them in decisions about their care and treatment. We observed patients who were not involved in decisions about their care. A number of patients told us there was little communication from staff, especially on arrival to the emergency department. One relative we spoke with said they were aware that assessments had been completed but the person completing them had not introduced themselves and neither patient nor relative were provided with any information or explanation about the tests. This left them without an understanding of the treatment and limited involvement in their care.

Another relative we spoke with had not been offered a chair for at least two hours while they were waiting with their relative.

Patients told us they were waiting on ambulances before being moved into the department where they then waited in the corridor. One patient told us they were not given any indication as to how long they would be waiting to be seen and no information about their condition. A relative of the patient told us they felt unsupported.

However, we did observe clear communication between the nurse in the navigator role and self-presenting patients. The nurse welcomed patients and visitors into the navigator room and provided explanations of the tests being completed and what to expect during their time in the department.

Friends and family feedback provided to the paediatric team was positive and included recognition of “good advice and instructions” given about a child’s care and treatment and “lots of information on display” in the waiting area.

Emergency Department Survey 2016

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the</td>
<td>8.8</td>
<td>About the</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>doctors and nurses examining and treating you?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall.</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
Is the service responsive?

Service delivery to meet the needs of local people

Facilities and premises were not wholly appropriate for the services delivered. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess, treat and care for patients.

Patients frequently queued in the corridor in the emergency department, where it was difficult to maintain their comfort, privacy and dignity. Data provided by the trust showed that between 23 January 2018 and 28 February 2018, a total of 1596 patients spent more than 15 minutes in the emergency department corridor. Daily, this ranged from six to 66 patients. A similar number was reported in March (1683), although April saw a significant reduction (663). On 27 March 2018 two patients spent over 12 hours in the corridor, with the longest wait being 14.7 hours.

During our inspection we saw patients queuing on trollies in the area around the ‘pit stop’, just inside the ambulance entrance to the emergency department, where patients were afforded no privacy. An overflow room, known as the star suite, with two curtained bays, was used to allow staff to perform, for example, ECGs and take blood, allowing patients some privacy. The room was also used by ambulance crews to transfer patients from their stretcher to a hospital trolley. When the department became very congested, patients were assessed on ambulances as there was no space in the ambulance entrance and at times, a shortage of trollies.

Patients did not have access to call bells in the corridor. There was one nurse, responsible for taking handover from arriving ambulance crews, as well as observing patients in the corridor. We were approached by a relative who requested a drink of water for their family member who was on a trolley in the corridor. They told us they had already asked the nurse stationed in the area, who had informed them that they were unable to leave the area to fetch a drink.

The waiting area for patients who self-presented to the emergency department was appropriately furnished and during our inspection there was adequate seating available for patients and other visitors. There was easy access to toilets, accessible to wheelchair users. However, we saw one accessible toilet did not have a pull cord alarm to allow a patient to summon assistance.

Signage in the entrance to the waiting area was not sufficiently prominent to guide people to the appropriate area of the department and we frequently saw patients who were unsure what to do or where to sit on arrival. Patients were triaged by a registered nurse known as the navigator who was stationed in a glass-screened room. The door was kept open to allow the nurse and the supporting healthcare support worker to see and hear what was going on in the waiting room. This did not allow for patient privacy but when we observed the process we noted that conversations were undertaken with sensitivity to patients’ confidentiality. If patients wished to discuss anything sensitive or were required to undress, there were other consulting rooms which could be used.

The children’s area was a securely accessed area, audio-visually separate from the main adults’ area. It was sensitively decorated, furnished and equipped with toys and there was a separate area for teenagers.

There was suitably furnished mental health assessment room located in the emergency decision unit. Although this did not meet recommended safety standards (see premises and equipment), it was a private and comfortable space.

There was a relatives’ room in the emergency decision unit. This room had comfortable seating and access to a toilet and tea and coffee making facilities. However, staff told us it did not meet the needs of the department. It was often used as a second mental health assessment room, even
though it was not designed as such. Staff expressed concerns that the location of the room meant that concerned or bereaved relatives were sometimes exposed to challenging and loud behaviour from patients on the unit experiencing mental health problems. There was a bereavement working group, which had produced plans to provide a bereavement suite; however, at present there was no funding for this to proceed.

**Meeting people’s individual needs**

The service took account of the individual need of patients, and had taken some steps to support patients in vulnerable circumstances or those with complex needs. However, we found there was limited understanding of the needs of patients living with dementia and little evidence of a strategy or tools to support this patient group.

There was an identified dementia champion in the emergency department. However, three nurses we asked could not identify this individual and demonstrated limited knowledge and understanding of the needs of this patient group. We did not see staff use symbols or other tools, such as wristbands, to alert all staff involved in their care that they may require additional support. Staff told us they had access to specific tools, such as ‘twiddle muffs’ which have been found to provide distraction for patients living with dementia. However, we did not see these in use. Nursing staff were in the initial stages of raising funds to adapt a cubicle in the department to provide a more ‘dementia friendly’ environment.

Staff in the emergency department had taken steps to support bereaved relatives. A butterfly symbol had been developed to alert staff that a deceased patient and bereaved relatives were present in the department.

The emergency department had improved services for patients with mental health needs. There was a mental health liaison team (MHLT), employed by a local mental health trust, which was based in the department and worked from 8am to midnight. There was a consultant psychiatrist who worked day time, Monday to Friday. There were usually three psychiatric liaison nurses on duty, staff, who supported the whole hospital. Staff spoke positively about this service which they told us was mostly responsive. A service specification had been agreed for the provision of this service. The service aimed to respond to urgent referrals within one hour and response times were monitored. Data provided by the trust showed that between May 2017 and April 2018, 44% of patients referred by the emergency department were seen within one hour, with 79% seen within four hours. The median waiting time was 1.4 hours.

The emergency department had used short term funding (winter pressure monies) to support the delivery of a child and adolescent mental health liaison service. This had been in operation since 1 March 2018. As a Monday to Friday service it was capturing around 50% of presentations through the department. The service had seen 35 patients and had admitted four and organised support for 31 young people at home. The consultant for paediatrics described the new service as life changing and said that the expertise and knowledge of the child and adolescent team had made them think differently about the management and interventions offered to children. Previously every child would have been admitted and would not have received expert mental health assessment whilst there.

Staff told us that out of hours, patients sometimes experienced lengthy delays to be seen by a mental health practitioner. The service was provided by the crisis team, employed by the local mental health trust. There was an on-call psychiatrist who worked at a local hospital, who could be called to attend, but staff told us this did not happen often. We asked for data to quantify delays out of hours but this was not provided.
There was a dedicated alcohol service during weekdays but limited access to advice for substance misuse.

There was a registered mental health nurse employed 24 hours a day, seven days a week in the emergency decision unit (EDU). These were agency staff, although the service had developed a business case for these staff to be permanently employed. The staff were not integrated into the mental health liaison team or the emergency department nursing workforce and they received no clinical supervision, except through the employing agency. However, staff in the EDU reported having a registered mental health nurse on duty improved care for patients.

**Emergency Department Survey 2016**
The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Access and flow**

Patients were not always able to access care and treatment in a timely way and in the right setting. The trust was consistently failing to meet national standards in relation to the time patients spent in the emergency department, the time they waited for treatment to begin and the time they waited for an inpatient bed.

Patients waited too long for their treatment to begin. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival in the emergency department to the time that their treatment begins is no more than one hour. The trust’s performance against this standard ranged from 49.4% to 63% from January to April 2018, with the worst performance in March 2018.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**
The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From April 2017 to March 2018 the trust failed to meet the standard, breaching it in all 12 months. The trust’s performance was consistently below the England average with a decline over time. In the latest period, March 2018, the trust’s performance was 71.0% compared to the England average of 84.6%. Performance was much improved in April, at 84%
In the week prior to our inspection, the trust’s four hour performance varied between 71.5% and 93.4% (a weekly total of 82.9%). Most breaches were attributable to unavailability of a specialty bed. Of the 377 breaches that week, 184 were due to unavailability of beds.

Patients in the emergency department experienced long delays waiting for an inpatient bed. From April 2017 to March 2018, the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently higher (worse) than the England average. There was deterioration in performance from April 2017 to January 2018, followed by an improvement until March 2018. In March 2018, the trust’s performance was 40.8% compared to the England of average 19.4%.
Number of patients waiting more than 12 hours from the decision to admit until being admitted

In the period from April 2017 to March 2018, 307 patients waited more than 12 hours from the decision to admit until being admitted. This is known as a 12-hour breach. The highest number of patients waiting over 12 hours was 73 in January 2018. Performance improved significantly in February and March and there were no 12-hour breaches in April 2018.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>980</td>
<td>58</td>
</tr>
<tr>
<td>May-17</td>
<td>1225</td>
<td>38</td>
</tr>
<tr>
<td>Jun-17</td>
<td>828</td>
<td>9</td>
</tr>
<tr>
<td>Jul-17</td>
<td>1080</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>1295</td>
<td>5</td>
</tr>
<tr>
<td>Sep-17</td>
<td>986</td>
<td>32</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1192</td>
<td>6</td>
</tr>
<tr>
<td>Nov-17</td>
<td>1239</td>
<td>2</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1513</td>
<td>52</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1496</td>
<td>73</td>
</tr>
<tr>
<td>Feb-18</td>
<td>1209</td>
<td>21</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1328</td>
<td>11</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Another key performance metric for emergency departments is the percentage of patients who leave the emergency department before being seen. This is indicative of patient dissatisfaction with waiting times. The standard is that this should be below 5%. From March 2017 to February 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average, except for January 2018 where it was better. Trust performance ranged from 2.3% in January 2017 to 3.3% in May and December 2017.

Percentage of patient that left the trust without being seen - Portsmouth Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From March 2017 to February 2018 the trust’s monthly median total time in A&E for all patients was similar to the England average.

In the latest period, February 2018, the trust's monthly median total time in A&E for all patients was 162 minutes compared to the England average of 156.

Median total time in A&E per patient - Portsmouth Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Patients were encouraged to report concerns about their care and treatment. We found leaflets in the reception area, which directed patients and visitors to the trust’s Patient Advice and Liaison Service (PALS). A receptionist told us if a patient or visitor told them they wished to complain, they would ask a senior member of staff to speak with them to see if their concerns could be resolved. Otherwise, they would be directed to the PALS office. There were PALS leaflets available, which contained contact details, including a telephone number, and email address. Another leaflet entitled “Why am I waiting?” set out the reasons why delays may occur in the emergency department and described the different pathways into and through the emergency department. It also invited patients to make a comment or suggestion, as described in the ‘Your experience matters to us’ leaflets, available in the department.

Complaints were investigated by appropriate senior staff and complainants received a full written response. We reviewed a sample of complaint responses and saw that concerns had been taken seriously, investigated thoroughly and sympathetically. A complaints database was maintained for the clinical service centre (emergency department and acute medical unit) and this was also overseen by the trust’s complaints department. Complaints were RAG rated to highlight the progress of their investigation and to ensure timely responses. Any delays were notified to complainants.

From January 2017 to December 2017 there were 116 complaints about urgent and emergency care (18.8% of total complaints received by the trust). The trust took an average of 38 working
days to investigate and close complaints; this is slightly longer than the time set out in their complaints policy which states all complaints should be closed within 30 working days.

The emergency department had introduced a system where a consultant was allocated each week to spend two days on non-patient facing duties, which included the investigation of complaints and incidents. This had significantly improved the response time to complaints which required medical input and investigation.

Clinical treatment and admission, discharge and transfer were the main subjects of complaint with 48% and 22% of complaints relating to these subjects. The table below shows a breakdown of complaints by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>56</td>
</tr>
<tr>
<td>Admission, discharge &amp; transfer</td>
<td>26</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>12</td>
</tr>
<tr>
<td>Communication</td>
<td>8</td>
</tr>
<tr>
<td>Patient property / expenses</td>
<td>3</td>
</tr>
<tr>
<td>Patient Care</td>
<td>2</td>
</tr>
<tr>
<td>Personal records</td>
<td>2</td>
</tr>
<tr>
<td>Patient status</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient delay and cancellation</td>
<td>1</td>
</tr>
<tr>
<td>Hospital acquired infection</td>
<td>1</td>
</tr>
<tr>
<td>Bed shortages</td>
<td>1</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Policy &amp; commercial decisions of NHS board</td>
<td>1</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
Is the service well-led?

Leadership

Clinical leadership for the emergency department was provided by the chief of service, a clinical director, an associate clinical director and a head of nursing, supported by two newly appointed interim matrons. They were supported by a general manager and assistant general manager. Staff told us that all of the local management team were visible and accessible and were frequently seen on the floor, providing help. The team were highly respected and staff told us they “have our backs”.

The leadership team appeared well informed and had a cohesive view of what needed to be done. Staff told us the executive management team was also very present. This included the chief executive, the chief nurse and the chief operating officer, who were all frequent visitors to the emergency department.

Historically, staff in the emergency department felt their service was under-valued and under invested in, compared with other trust services. We saw a significant shift in thinking at this inspection. There was a universally held view that the executive management team understood and owned the challenges faced by the emergency department and were focussed on implementing system-wide change by holding all partners to account. The agreement of the admissions policy, led by an emergency department consultant and the medical director was seen as a key milestone in terms of whole-hospital ownership of emergency department targets.

Vision and strategy

The overall vision for the service was to develop an urgent care floor or ‘one stop shop’ for all unscheduled care. This was in an early phase of development and preparatory work was expected to take two years under the direction of a project board, supported by management consultants. Most staff we spoke with seemed to be appraised of this vision and early plans had been discussed at governance and quality meetings. The chief of service told us there was to be some reorganisation of the responsibilities of the management team in order to allow them to contribute in the development of this vision into a strategy.

There was a system-wide review of capacity and demand to establish the capacity required to improve flow across the system and to decrease the bed occupancy levels across the trust. There was an A&E delivery board, led by the chief executive and attended by external partners, which provided strategic and operational leadership to ensure capacity planning was undertaken jointly across the whole health and social care system. The local emergency department management team were not members of this forum but attended by invitation.

There were a number of work streams underway to improve performance, although at this stage there was no clearly defined plan setting out what needed to change for next winter. There was an urgent care transformation board, supported by an external partner, and a number of work streams had been identified to take forward. A Winter 2017/8 Evaluation Report was presented to the April 2018 A&E Delivery Board and was to be used to develop the winter plan for 2018/19. In addition, an external consultancy firm was engaged to undertake diagnostic work to support the plan.

The emergency department management team talked about now having “head space” to look to the future as they emerged from a very busy winter. The last month had seen relatively good patient flow within the hospital, resulting in less pressure on the emergency department, allowing it to “function normally”. They talked about “re-calibrating”, seeing four hour performance as an
achievable goal, rather than focussing on 12-hour beaches, as had been the case in the winter months. There were plans to examine the effectiveness of the pit stop function, promoting and ensuring consistent use of the safety checklist and maximising the use of the GP-led urgent care service.

It was noted at the Governance and Quality Committee meeting held in January 2018 that the clinical service centre (CSC) did not have one over-arching quality improvement plan. It was agreed the team would meet to discuss the creation of a master plan, which would serve as the CSC’s CQC evidence/assurance database. We requested this; however, the trust advised this was in draft and it was not shared with us.

**Culture**

Staff in different roles told us they enjoyed working in the emergency department. They felt well supported, valued and respected by peers and managers. Teamwork, peer support and camaraderie were cited by many staff as the reasons they enjoyed coming to work. Many staff described their work colleagues as their second family and told us they would not want to work anywhere else. They told us there was respect for seniority and the chain of command but they saw each other and treated each other as equals.

Many staff described the difficult winter they had experienced, when for many months there was relentless pressure due to unprecedented demand for services and insufficient capacity. Staff had been fatigued and demoralised but over the last month, as the pressure on the emergency department had reduced, morale was improved and there was a palpable feeling of optimism shown by the staff we spoke with.

The head of nursing told us there was much to do to improve the working lives of nurses; the appointment of two interim matrons was a key step to move this forward. The department had recently introduced debrief sessions for nurses at the end of their shift, where they could jointly discuss with their colleagues and the nurse in charge any concerns and what had gone well. Staff were also given the opportunity to discuss concerns with the nurse in charge on a one to one basis. Staff spoke positively about this as it allowed them to “offload”, as opposed to taking concerns home with them. The department had recently introduced “hug in a jug” which allowed staff to send anonymous appreciative messages to colleagues by completing a slip of paper and placing it in jug in the staff room. Staff were also able to nominate colleagues for a monthly star colleague award. Recipients of this award received a box of chocolates and were presented with a certificate recognising their contribution or achievement and this was displayed in the department for all to see.

Staff felt encouraged and able to report concerns. They told us they could report concerns at any level without fear of retribution. Staff knew how to contact the trust’s “Freedom to Speak up Guardian”.

We noted some behaviours exhibited by a few senior nurses during our inspection which did not present a professional image to staff or visitors. We reported concerns about one particular nurse who we observed raising their voice to both a patient and, on another occasion, their colleagues. Although the majority of staff welcomed us in the department there was a small minority who were openly hostile and this did not go unnoticed by their colleagues.

**Governance**

There was a lead consultant for governance and the head of nursing led on quality and safety for nursing matters. They were supported by a governance coordinator and governance administrator.
There were monthly meetings of the governance and quality committee, chaired by the head of nursing, although these meetings did not take place in December 2017 and March 2018 due to operational pressures. We noted there was no senior medical representation for the emergency department at the January meeting. There were standing items on the agenda each month and, in addition, there was a different focus each month.

There was good managerial oversight of complaints and incidents. The senior management team was supported by a governance coordinator and an administrator, who maintained a database of complaints and incidents, arranged for these to be reviewed by the management team and monitored the progress of investigations. There were weekly panels to review incidents which were graded ‘moderate harm’ or above.

Governance newsletters were produced each month, sent to all staff by email and displayed in the emergency department.

We were told about weekly observation sessions undertaken by a clinical and a non-clinical staff member to assess patients’ experiences. These were known as ‘Sit and see’ and focussed on dignity and respect. There were plans for emergency department staff to receive training from the trust’s Head of Patient Experience to undertake these sessions. We saw notes from three recent sessions. One had focussed on observation of the pit stop area and a second took place in the area of the department known as Majors A. These two sessions had identified mainly good staff interaction with patients and that patients’ needs were responded to promptly. It was identified that there was a shortage of pillows in the department and this had been followed up and escalated to the senior management to address. The third session focussed on the navigator role in the main reception area and took place in response to concerns we raised during our inspection in February 2018. A number of modifications had been made to the process and a standard operating procedure developed to clarify the process. There were plans to repeat audits weekly to provide assurance of the safety and effectiveness of this process.

**Management of risk, issues and performance**

There was some evidence of managerial oversight of risk and performance but assurance systems were not fully developed or embedded.

The service maintained a risk register which recorded known risks and rated them according to their potential impact. Risks documented did not fully align with what staff and managers told us were on their ‘worry list’ and we judged there were some notable omissions. The highest rated risks related to failure to deliver the national four-hour target, the impact on patient experience of persistent queuing and insufficient nursing staff to meet demand. The safety risks associated with delayed ambulance handover, delayed initial assessment, delayed time to treatment, and prolonged waits for a bed (12-hour breaches were the most common cause of a serious incident) were not captured. The safety risks associated with poor record keeping (failure to consistently complete safety checklists) and falls (two serious incidents had occurred) had also not been captured.

Each risk on the register had an identified lead manager and a review date. However, there was no detail recorded of any actions completed or planned to mitigate the risks. We saw that the risk register was regularly reviewed at governance and quality meetings.

At our last inspection in February 2018 we were concerned that the emergency department had not reviewed or audited safety systems used to identify and prioritise the sickest patients and ensure regular patient monitoring. These systems are crucial in a frequently crowded emergency department. Performance data showed that patients waited too long to be handed over by
ambulance staff and to receive an initial assessment by emergency department clinicians but these processes had not been reviewed or audited. Safety checklists designed to prompt staff to provide hourly checks and interventions were not being completed consistently to provide assurance that patients’ safety and comfort were appropriately monitored.

In their monthly monitoring report to CQC the service reported that during April 2018, when patient flow in the hospital and emergency department operational performance improved, there was an opportunity to examine these processes and to identify process issues, which were “previously obscured by flow issues”. This included joint work with the ambulance service to improve the efficiency of the handover process and to verify data to ensure that it is accurate. As referred to elsewhere in this report, the streaming process for self-presenting patients had also been reviewed and refined, a standard operating procedure developed and a snapshot audit performed to provide assurance that staff were complying with this. There were plans for this scrutiny work to continue and for further examination of the pit stop function, and the utilisation of other care pathways, including ambulatory emergency care and the urgent care centre.

There was renewed focus on the completion of the safety checklist, which was being led by the head of nursing. Early results showed improvement, although currently, meaningful data was not being captured, as there was not a fully developed system to audit patient records. The trust’s nursing documentation audit tool was focussed on ward-based care. The trust told us the newly appointed matrons were working with the trust’s Practice Transformation Nurse to develop a qualitative audit tool which was compatible with the emergency department patient records system. We noted that the most recent (May 2018) report to the trust clinical effectiveness and mortality review group reported “recent audits demonstrate this is being used as intended.” We were concerned that this statement belied the true position with regard to the effective use of this tool, which we found was not embedded; a position which was acknowledged by the head of nursing.

Information management

The trust collected, analysed, managed and used information to support all its activities. There was real time information available to show departmental activity and operational performance and there was a daily review of metrics and breach analysis by the senior management team.

Engagement

The service used the friends and family test to capture patients’ feedback. Response rates were low. This was noted at governance and quality meetings and department was seeking to recruit more volunteers to address this.

We saw a post box in the emergency department waiting area but there were no comments cards or pens available. We advised a receptionist, who immediately rectified this. We thought the post box was not in a very prominent place. Reception staff told us clinical staff were encouraged to hand out cards at the end of a patient’s treatment.

In the children’s area we saw adapted, child friendly comment cards were available and a bright red post box to encourage children to give feedback. There was a large display of previous comments, both positive and negative on the wall, which was bright and attractive.

Staff engagement in the emergency department was described to us by staff as good. There was regular communication at staff handovers, monthly newsletters were sent to all staff via email and there was a closed social media page where staff could engage with one another. There were a
number of working groups established to review different stages of the emergency department patient pathway.

The emergency department was about to introduce a ‘happy app’ (a smart phone application) which would encourage staff to share “minor grumbles”.

**Learning, continuous improvement and innovation**

There were a number of quality improvement projects which were underway in the emergency department. The department had recently been successful in obtaining funding from Health Education England (Wessex) to develop a nurse training programme in advanced sepsis care. This would allow specially trained nurses to assess patients who were identified as having sepsis and to administer antibiotics and fluids under a patient group direction (PGD).

Senior leaders within the emergency department had developed a number of mechanisms by which they could better understand mental health presentations to the department. Managers had implemented three daily status reports on all mental health patients across the hospital, along with the introduction of a clearer care pathway and documentation for both children and adults with mental health problems. Staff had received better training on mental health, including ‘bite-sized’ training delivered by the emergency department matron. There was a mental health and capacity board which was chaired by the medical director. There was a cross-system working party to develop the vision for mental health and a mental health assessment unit, which included local mental health trusts and commissioners.
**Medical care (including older people’s care)**

**Facts and data about this service**

The medical care service at Portsmouth Hospitals NHS Trust provides care and treatment for acute nephrology, audiology, cardiology, gastroenterology, general medicine, neurological rehabilitation, acute older people’s care, respiratory medicine and stroke medicine. There are 580 medical inpatient beds located across 24 wards at Queen Alexandra Hospital. A list of inpatient wards at Queen Alexandra Hospital is as follows: C5, C6, C7, D2, D3, E4, E6/7, E8, F1, F2, F3, F4, F5, F6, F7, G1, G2, G3, G4, G6, G7, G9, Acute medical unit.

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 56,875 medical admissions from December 2016 to November 2017. Emergency admissions accounted for 25,511 (44.9 %), 1,274 (2.2 %) were elective, and the remaining 30,090 (52.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 18,755, down 6% compared to previous year
- Gastroenterology: 13,782, up 3% compared to previous year
- Rheumatology: 6,193, down 3% compared to previous year

(Source: Hospital Episode Statistics)

We carried out inspections of the urgent medical pathway in February and March 2016, September 2016 and February and May 2017. During those inspection we inspected some areas of the trust medical services, but did not inspect them all. This current inspection, is the first comprehensive inspection of medical services since 2015. Comparisons to previous ratings relate to the inspection carried out in 2015, unless otherwise stated.

**Is the service safe?**

**Mandatory training**

Although overall nursing staff met the trust target for completion of mandatory training, there were low rates of compliance with some mandatory training. Medical staff did not meet the trust’s target of 85% compliance (95% for information governance) for completion of mandatory training.

Inspections of the service since 2015 identified medical services had consistently not met the trust’s mandatory training targets. Following our inspection in February and May 2017, we served a warning notice on the trust that required them to make significant improvements about meeting their mandatory training targets. Data provided by the trust for this current inspection showed that overall nursing staff for the medicine Clinical Service Centre met the trust target. However, despite a small improvement (78% compared to 77%) over all medical staff completion of mandatory training remained significantly below the trust target.

**Mandatory training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of mandatory training apart from information governance which had a target set of 95%.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for medical staff in medicine is shown below:
The overall completion rate for medical and dental staff was 78%. Five out of the 16 modules met the trust target.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>278</td>
<td>294</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>277</td>
<td>294</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>276</td>
<td>294</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>266</td>
<td>294</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>266</td>
<td>294</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>199</td>
<td>250</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>234</td>
<td>294</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>231</td>
<td>294</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>191</td>
<td>259</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>189</td>
<td>261</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>203</td>
<td>294</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>180</td>
<td>264</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>197</td>
<td>294</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>105</td>
<td>264</td>
<td>40%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>2</td>
<td>6</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Specialty Specific Fire Safety</td>
<td>2</td>
<td>7</td>
<td>29%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff was 78%. Five out of the 16 modules met the trust target.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for nursing staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>750</td>
<td>751</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>749</td>
<td>751</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>749</td>
<td>751</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>748</td>
<td>751</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>747</td>
<td>751</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>747</td>
<td>751</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>726</td>
<td>751</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>678</td>
<td>704</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>716</td>
<td>751</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>717</td>
<td>751</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>629</td>
<td>664</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>706</td>
<td>751</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>587</td>
<td>683</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>559</td>
<td>683</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>551</td>
<td>684</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>540</td>
<td>708</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>529</td>
<td>726</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>324</td>
<td>700</td>
<td>46%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Acute Pain Management (Registered Staff)</td>
<td>7</td>
<td>19</td>
<td>37%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 3 years</td>
<td>0</td>
<td>3</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 90%. 13 out of the 20 modules met the trust target with four of these achieving 100% compliance.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Conversations with staff indicated they had different experiences of accessing mandatory training. For example, nursing, therapy and medical staff on the hyper acute stroke unit (HASU), stroke ward and stroke rehabilitation ward said they had no problems accessing mandatory training. They said they received electronic alerts to remind them they needed to update their mandatory training. However, staff on other wards said due to staffing shortages they had little time to complete mandatory training.

Some records, such as mandatory training record, could not be accessed unless the ward manager was on duty. Staff on C5 ward told us they could not access any mandatory training records because the ward manager was on leave.

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew where to seek advice.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in relation to safeguarding vulnerable people. However, at our inspection of the urgent medical pathway in February and May 2017, we identified staff did not always recognise safeguarding incidents. This meant staff did not always put appropriate safeguarding process in place, which included failing to make safeguarding alerts. Following our inspection in February and May 2017 we served a warning notice on the trust that required them to make significant improvements about safeguarding vulnerable patients. In the period between the 2017 inspection of the trust and this inspection, our monitoring of the service identified ongoing concerns with the trust’s management of safeguarding concerns. This included staff not recognising safeguarding concerns, and staff not reporting and taking appropriate action in response to safeguarding concerns. At this current inspection, we identified medical services had made improvements about safeguarding vulnerable people.

At the inspection in February and May 2017, we identified that the trust did not provide level 2 or 3 adult safeguarding training. This did not meet the recommendations set out in the “Adult Safeguarding Levels and Competencies for healthcare professionals Intercollegiate Document 2016” which states “Level 2 should be the minimum level of competence for all qualified healthcare staff” and gives guidance about which staff should complete level 3 adult safeguarding training.

Data provided by the trust at this current inspection indicated the trust still did not provide level 2 or 3 adult safeguarding training. However, contrary to the information the trust provided, many staff told us they had completed level 2 adult safeguarding training.

**Safeguarding training completion rates**

Safeguarding training completion rate information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for medical and dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>


The overall completion rate for medical and dental staff was 86%. The trust target was met for two of the three safeguarding modules.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Numb er of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>249</td>
<td>260</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>278</td>
<td>294</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>205</td>
<td>294</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>13</td>
<td>19</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 98%. The trust target was met for three of the four safeguarding modules with safeguarding adults (level 1) and safeguarding children (level 1) having 100% compliance.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

During the inspection we asked staff of all grades and professions about their understanding of safeguarding vulnerable adults and children. Most staff demonstrated in conversations a good understanding about safeguarding and who they needed to report safeguarding concerns to.

**Cleanliness, infection control and hygiene**

The service controlled inflection risk well. Staff kept themselves, equipment and premises clean. They used control measures to prevent the spread of infection.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about cleanliness, infection control and hygiene. However, our inspections of the urgent medical pathway since 2016, identified medical services did not comply with the Health and Social Care Act Code of Practice on the prevention and control of infections (2015). At those inspection staff did not always follow the trust’s infection control policies and procedures to protect patients from the risk of cross infection. Following our inspection of the service in February and May 2017, we served a warning notice on the trust that required them to make significant improvements to their infection control practices. At this current inspection, we identified medical services had made improvements to their infection control practices.

Training records showed nursing staff met the trust’s target for completion of infection prevention and control training, and medical staff nearly met the target (85% completion compared to the trust target of 90%).
On the wards, we observed staff followed the trust’s infection prevention and control procedures. Staff washed their hands before and after attending to patients and were seen to adhere to the trust’s bare below elbows policy. Staff had access to and used personal protective equipment (PPE) such as gloves, aprons and eye protection. Staff used sharps boxes appropriately, ensuring they did not overfill them. The openings to the sharps boxes were such that people could not put their hands in them and staff closed and secured them when they were three quarters full. These were all improvements since the last inspection.

All wards had side rooms, which staff could use to isolate patients who had infectious conditions, to reduce the risk of cross infection. Where side rooms were used of isolation purposes, there were signs outside the rooms to inform visitors of the precautions they had to take. There was sufficient supply of PPE such as disposable gloves of different sizes, aprons and where needed face masks. We saw nursing staff, medical staff, allied health professionals (AHPs) and visitors using PPE and disposing of it in accordance with trust procedures. However, only the oncology and chemotherapy ward and the private patient ward had side rooms with entrance lobbies and facility to manage the air flow to further reduce risk of cross infection. These were used appropriately on the oncology and chemotherapy wards to protect patients who were immunocompromised due to their ongoing treatment. However, the side rooms on the private patient ward were not used to manage the safe care of patients with infectious conditions.

At previous inspections, it was identified that in periods of escalation when an extra two beds were added to the pink area of the Acute Medical Unit (AMU) there was an increased risk of cross infection due to the closeness of the position of beds and patients. At this current inspection, we found the trust had reconfigured the area so that it never exceeded the five dedicated bed spaces, this reducing the risk of cross infection occurring.

Infection prevention and control was managed well in the endoscopy units at both Queen Alexandra hospital and the satellite unit at Gosport War Memorial hospital. The endoscopy units had dedicated staff to decontaminate used equipment. Staff followed nationally recognised processes to decontaminate the equipment. This included tracking of scopes, which include the time taken to clean and detail of the patient staff used the scope on. Staff wore full PPE (eye visor, gloves and aprons) and washed their hands before and after decontaminating equipment. Air pressures in the decontamination room was set to keep the room charged with clean air, which promoted effective decontamination of the equipment. Tracing and effective auditing ensured staff used endoscopy equipment within the required timescale (three days) after decontamination. Throughout the endoscopy units there was effective dirty to clean equipment flow. However, the age of the decontamination units meant they required frequent maintenance. There were regular occasions when staff could not use all the decontamination units or there was restricted use of some of them. Information provided following the inspection showed staff reported faults as they occurred and they took decontamination units out of action or restricted their use until the faults were rectified.

The trust had a service level agreement with another provider to carry out general cleaning of the wards and units which set out the cleaning requirements. This same provider was responsible for the cleanliness of bed side curtains. Nursing staff did not know the frequency bedside curtains were changed. The cleaning provider confirmed they changed the curtains following national guidance every six months, or more frequency if requested by ward staff because of visible soiling, and washed them at a minimum of 60 degrees Celsius. However, ward staff had no assurance process that the cleaning provider followed the national guidance.
Cleaning of clinical equipment was the responsibility of nursing and other clinical staff. The trust used the National Patient Safety Agency (NPSA) audit tool to monitor the cleanliness of ward environments and equipment. The trust set a target that wards must achieve a 95% score in the NPSA audits. Results for January, February, March and April 2018 showed that overall medical wards achieved a score of 95% or over in the audits. However, F4 ward scored below 95% for all four months and the blue area in AMU scored below 95% for three of the four months. There were no associated plans to support improvements to the cleanliness of the wards.

The trust's infection prevention team supported trust wide and ward based surveillance of healthcare associated infections and infection prevention practices. This included ward surveillance for hand hygiene, environmental cleaning, device care, the cleanliness of medical equipment and surgical site infections.

Following the inspection, the trust provided results for the April 2018 hand hygiene audit. The audits included observing hand hygiene practices of a range of staff, including nursing medical and AHPs. The audit showed most wards achieved the trust target of 95% or above for compliance with the trust hand hygiene procedures. However, because the trust only provided results for April, we could not identify whether the wards that did not meet the trust target were an isolated occurrence or whether there was a systemic failure to meet the trust target in these areas.

Performance boards on the wards displayed their previous months hand hygiene and NPSA clean environment audit results. Some ward’s performance boards detailed the action staff were taking in response to the previous months audit results. Other wards did not display any detail about actions they were taking in response to environmental audit results.

Medical services provided data about hospital acquired infections for the period 1 April 2017 to 31 March 2018. They had not yet confirmed the final figures for 1 January 2018 to 31 March 2018, but expected any changes to the data, once it as finalised to be minimal.

For the period 1 April 2017 to 31 March 2018 there had been 21 cases (13.33 per 100,000 bed days) of hospital acquired Clostridium Difficile (C. Diff.) in medical services. This was below the national rate. Information in the trust’s Infection Prevention annual report 2016/17 detailed the prevalence of C. Diff. cases in the trust had consistently been below (better than) the national rate since 2008.

For the period 1 April 2017 to 31 March 2018 there had been three cases (1.67 per 100,000 bed days) of hospital acquired methicillin – resistant staphylococcus aureus (MRSA) blood stream infections, two of which were classed as unavoidable and one as avoidable in medical services. This was above (worse than) the national rates and a deterioration from the previous year when there had been only one case trust wide. This did not meet the trust’s target of zero avoidable MRSA blood stream infections.

For the period 1 April 2017 to 31 March 2018 there had been 17 cases (8.33 per 100,000 bed days) of hospital acquired methicillin sensitive staphylococcus aureus (MSSA) blood stream infections in medical services. This was below (better than) the national rate. Except for the year 2014/15, trust wide the prevalence of hospital acquired MSSA blood stream infections was consistently below (better than) the national rate since 2012/13.

For the period 1 April 2017 to 31 March 2018 there had been 34 cases (21.93 per 100,000 bed days) of hospital acquired Escherichia coli (E coli) blood stream infections in medical services. This was below (better than) the national rate.
For the period 1 April to 31 March 2018 there had been 10 cases (5.55 per 100,000 bed days) of hospital acquired Klebsiella blood stream infections in medical services. This was below (better than) the national rate.

For the period 1 April 2017 to 31 March 2018 there had been 10 cases (4.44 per 100,000 bed days) of hospital acquired pseudomonous blood stream infections in medical services. This was below (better than) the national rate.

During our inspection of medical service, we observed most wards, units and equipment were visibly clean. When we identified equipment that was not clean, staff addressed this and carried out cleaning of the equipment promptly. However, cracked flooring in the discharge lounge presented a risk that the floor could not be cleaned effectively. The unit manager said they had reported the condition of the floor on several occasions, but the trust had not taken any action to address it.

Patients we had conversations with mostly commented that wards and equipment were clean and tidy. A patient on C6 ward made the comment that the “Cleanliness is amazing.”

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

Inspection of the urgent medical pathway since 2016 identified staff in medical services did not always check the resuscitation trolleys according to the trust policies and procedures. Inspection of the service in February and May 2017 identified there were no washing or showering facilities for patients in the pink area of AMU. Patients had to access washing and showering facilities in the AMU link corridor. At the inspection in February and May 2017, we identified that staff did not carry out any assessments of the risk for medical patients cared for in areas such as recovery and the discharge lounge during period of escalation. Following our inspection in February and May 2017, we service a warning notice on the trust that required them to make significant improvements about these issues. At this current inspection we found the service had made some improvements with regard to the concerns identified in the warning notice.

At this current inspection, we found the number of inpatients meant that areas, such as the recovery area were not being used of escalation purposes. Following an assessment of the discharge lounge area, it was identified the isolation of the unit meant there was a risk medical assistance could not be provided in a timely manner and there were no washing facilities for patients in the discharge lounge. As a result, the trust no longer used the discharge lounge as an escalation area.

Staff in areas that had been used as escalation areas spoke about the assessments carried out to ensure the areas were safe to use and the actions taken to mitigate identified risks. This included providing hand bells to all patients so they could summon assistance.

The pink area of AMU had been reconfigured and there were now five dedicated bed spaces. Staff said this number was not exceeded. Patients continued to have to access bathing and toileting facilities in the link AMU corridor. However, the service reported they had received no complaints from patients about this. The trust also reported they had plans to improve the overall environment of the AMU, which would address the toilet and bathing facilities in the pink area. The trust did not give a time scale for these improvements to be made.

In areas, such as the cardiac day unit (CDU), used as escalation areas in times of bed pressures, the units had strict criteria for the patients they admitted during periods of escalation. This meant patients were not put at risk due to lack of appropriate equipment, facilities and staff skills.
However, there was variation across the wards and units as to how established this process was. The clinical lead for the urgent care pathway said the process was still being embedded into all areas.

We found emergency equipment, such as resuscitation equipment, was available and in most cases, checked by staff daily to ensure all equipment was available. Records evidenced staff carried out the daily checks. However, on F3 ward, records for checking the resuscitation trolley did not evidence staff had carried out checks on 21 February, 6 and 12 March and 6 April 2018. E4 ward, a nurse led complex discharge unit, did not have their own resuscitation trolley. If needed they used the resuscitation trolley on the adjoining ward. We saw this was easily accessible the ward manager said, that although the ward staff on the adjoining ward were responsible for carrying out the daily checks of the trolley, when she was working she carried out a visual check that this had been carried out. However, there was no process to document this visual check, and it was not evident that the visual check was carried out by other ward staff when the manager was not on duty.

We found two isolated incidents where staff did not store substances hazardous to health securely. On one area of AMU and on one ward we found a cleaning chemical in areas that were accessible to patients and the public.

Across all wards and units, equipment had servicing stickers that gave staff assurance the equipment was services and maintained in line with trust policy and manufacturer’s guidance. All the servicing stickers we reviewed, showed the trust had carried out servicing of the equipment within the previous 12-month period.

Staff across all wards said they could access pressure relieving equipment and bariatric equipment in a timely manner.

The environment of some areas posed a challenge to delivering safe care. The flooring in two areas of the discharge lounge was cracked and posed a trip hazard. The unit manager said he had reported the condition of the floor on several occasions, but the trust had not yet taken any action to address it. A temporary solution of covering the cracks with tape was in place, but the tape in one area was splitting because the cracked surface was cutting through the tape. This was not detailed on the medical CSC risk register.

G4 ward, a short stay frailty unit, had 21 beds, seven of which were in side rooms with poor visibility. A high proportion of patients on the ward had dementia and were assessed as being at high risk of falls. Due the layout of the ward, staff told us, it was difficult to observe patients and intervene in a timely way to reduce the risk of falls and associated harm. However, there was no evidence to demonstrate the risk to patients perceived by staff was actualised. From April 2017 to April 2018 there were 29 falls with harm reported (none in G4 ward) and 148 falls with no harm reported (10 in G4 ward).

Assessing and responding to patient risk

Staff did not always assess, monitor or manage risks to people who used the service.

Inspections of the urgent medical pathway since 2016 identified staff did not always detail actions in care plans that staff needed to take to reduce identified risks to patients. For some patients where staff identified risks and detailed the action required to mitigate the risk, actions were not always carried out. Following our inspection in February and May 2017, we served a warning notice on the trust that required them to make significant improvements about these issues.
At this current inspection we found staff still did not always detail the actions needed to reduce identified risks to patients. Staff did not always complete all required assessments of risks to patients. This meant staff could not be assured patients had all their risks identified and addressed. Staff did not always fully carry out ongoing monitoring to provide continual assessment of risk, such as fully completing fluid record charts. However, at the time of the inspection there was no evidence that this lack of detail had resulted in harm to patients.

In AMU we observed it was common for patients to have bed rails raised. Use of bed rails has an associated risk of entrapment. Nurses completed assessments about the risk of the use of bed rails, but there was no evidence they reviewed these to identify whether the need for use of bed rails was still present or that the risk had been reviewed.

On D1 ward, (an orthopaedic and trauma ward where medical outliers were cared for), we reviewed nursing care records for seven medical patients, we found gaps in the records for four of these patients. The term medical outliers, refers to when a medical patient, due to lack of availability of medical beds, is cared for on a non-medical ward such as a surgical ward. Nursing staff did not make entries in the intentional rounding records, did not making entries in the fluid intake monitoring charts, did not detail about the care and treatment of a pressure ulcer and did not detail how to reduce the risk of falls for a patient identified as at risk of falls. For one patient who had diabetes, staff detailed in their care plan “blood glucose recorded on proper sheet.” Staff did not include the frequency of blood glucose monitoring, what range the blood glucose should be in or what action staff needed to take if the blood glucose readings were outside a safe range.

On F3 ward for one patients care plan did not match the instructions from the speech and language therapist. The speech and language therapist detailed on 6 February 2018 “Continue on oral trials. Wait for breathing to settle between sips of fluid. Six teaspoons of stage 2 fluids three times a day.” Nursing staff had detailed in the patient’s care plans, dated 9 February, “record all oral intake.” There was no reference to the speech and language therapist instructions and there was no further detail from the speech and language therapist to indicate a change on their instructions. This meant there was a risk to the patient that they might aspirate and develop a chest infection.

The management of patient’s naso gastric tubes (NG) on the hyper acute stroke unit (HASU) did not always fully protect patients from risks associated with the use of NG tubes. One patient on the on the hyper acute stroke unit with an NG tube in place had an ‘enteral feeding plan NG position check’ document which instructed, “Position of NG must be checked on insertion and then daily if continuously feeding or before each use of intermittent feeding”. There was no record that staff had checked the position of the NG tube on 12, 13, 14 and 15 April 2018.

Assessments for some patients included the need for staff to monitor food and fluid intake. However, for many patient’s staff did not fully complete food monitoring charts. For example, we reviewed the notes for one patient on C7 ward, who had a food record chart in place which detailed that on 16 April 2018 they had only had orange juice and custard and a banana. Their food record chart for 17 April detailed the patients had eaten nothing that day. However, we observed staff supporting the patient to eat a pudding. Failure of staff tor record food and fluid intake accurately meant there was a potential risk that malnutrition or dehydration would not be promptly identified.

On G1 ward, one patient whose white board above their bed, detailed they required two hourly repositioning. We reviewed their care records and did not find evidence that this had been carried out. On 16 and 17 April 2018, nursing staff recorded they repositioned the patient at five or six
hourly intervals. Failure to reposition the patient at the planned intervals meant the patient was not fully protected from the risk of developing pressure ulcers.

We reviewed the records on a patient on the Acute Medical Unit (AMU) Staff had not completed a falls prevention and assessment care plan. One patient on AMU fell whilst we were inspecting. Staff said they had identified the patient as being at risk of falls, but they had not completed any risk assessments or plan of care around reducing the risk of falls. For a second patient on AMU, nursing staff detailed in their moving and handling risk assessment and care plan that the patient needed to be transferred from bed to chair with the use of a sling hoist. However, nursing staff had not included detail about the size of sling staff needed to use to ensure the patient was transferred safely and without risk of injury.

On F6 ward, we reviewed the notes of a patient admitted the previous day and found nursing staff had not completed a nursing assessment or care plan. Detail on the board above the patient’s bed indicated they were on a restricted fluid intake. There was no guidance about how much fluid the patient was allowed and staff did not complete a fluid record chart for the patient. This meant staff did not know how much fluid the patient had. Staff could not be assured the patient as not at risk of harm due having too large a fluid intake.

Risks assessment to self, others and from others were not routinely completed for patients with a mental health or learning disability diagnosis. We did see two enhanced care and observation risk assessment forms for patients who required enhanced observation, but these had been completed as a reactive measure after an incident rather than proactively in response to assessment and identification of risks.

Patient moves per admission.

It is nationally recognised that the number of bed moves a patient experiences whilst in hospital has a negative effect on their health and wellbeing. The trust was only able to capture moves from a specific ward and was not able to provide the number of patients who did not move ward.

From January to December 2017, 7,594 patients moved once in medicine, 627 patients moved twice and two patients moved three times.

(Source: Routine Provider Information Request (RPIR) P51 – Bed moves)

As part of their conditions of registration with CQC the trust was required to submit data about the number of overnight bed moves patients experienced during their admission. Data submitted by the trust showed that between February 2017 and February 2018, for medical services the number of bed moves at night (for clinical and non-clinical reasons) ranged between 1228 and 1869 per month. The largest number of overnight bed moves occurred in July 2017 (1859 patient bed moves) and the lowest number occurred in September 2017 (1228 patient bed moves). However, the figures showed a slight improvement over the course of the year. The number of overnight bed moves in February 2017 was 1552, compared to an improved figure in February 2018 of 1385. The trust also submitted data about the number of those overnight bed moves that involved vulnerable patients. This included patients who had cognitive impairment, were identified as at risk of falls, were subject to a Deprivation of Liberty Safeguards authorisation or were sectioned under the Mental Health Act. This showed that between 200 and 418 vulnerable patients were subject to bed moves during the night for the same period. However, there was no over improvement on these figures for the year. In February 2017 there were 300 vulnerable patients who experienced a bed move overnight. In February 2018 this number had increased to 240.
The trust followed a nationally recognised sepsis care bundle, to identify and treat patients with suspected sepsis. The trust carried out audits about the management of patients with suspected sepsis. Results from the audits from 1 April to 31 December 2017 showed good compliance with meeting standards for screening patients for sepsis but poor compliance with timely commencement of intravenous antibiotic therapy. The audit results showed the inpatient services (which included medical services), compliance rate with screening patients for sepsis ranged between 89.5% to 100%. For the period 1 April 2017 to 30 June 2017, 85 patients out of 89 who required sepsis screening received it. For the period 1 July 2017 to 30 September 2017, 71 patients out of 73 who required sepsis screening received it. For the period 1 October 2017 to 31 December 2017, 88 patients out of 95 who required sepsis screening received it. Out of those inpatients who were identified as requiring intravenous antibiotic therapy for sepsis, the trust consistently scored under 50% compliance with meeting the national target that antibiotics should be administered within 60 minutes of sepsis diagnosis. For the period 1 April 2017 to 30 June 2017, only 31 patients out of 76 who required antibiotic therapy received it within 60 minutes. For the period 1 July 2017 to 30 September 2017, only 25 patients out of 65 who required antibiotic therapy received it within 60 minutes. For the period 1 October 2017 to 31 December 2017, only 34 patients out of 78 who required antibiotic therapy received it within 60 minutes.

The trusts annual infection prevention report for the period 1 April 2016 to 31 March 2017 detailed how well the trust performed against the Commission for Quality and Innovation targets for the detection and management of sepsis. This showed that for the period January to March 2017, the trust was performing above the 90% target for inpatients screened for sepsis, but below the target for patients with suspected sepsis being treated with intravenous antibiotics within 60 minutes, (39.5%).

Staff used a nationally recognised tool, the Early Warning Score (EWS) to identify and escalate patients at risk of deteriorating. Staff recorded the results from patient observations onto the trusts electronic patient recording system, where a score was assigned to the entry. The score indicated when staff needed to repeat the patient’s observations or whether more urgent actions was required, such as escalation to medical staff or to the critical care outreach team. At the previous inspections of the urgent medical care pathway, we found staff did not always respond promptly or appropriately to changes in patients early warning scores. Our review of patient records, electronic records and observations during this current inspection identified staff responded to changes in patients early warning scores in an appropriate manner, following the guidance of the system.

However, the trust’s audits of use of the EWS showed that between March 217 and February 2018 patients who had a higher EWS score (at increased risk of deterioration) were less likely to have their repeated observations carried out in a timely manner when compared to those who had low EWS scores. The data showed that for the medical Clinical Services Centre (CSC) compliance with carrying out observations on time for patients who scored six or more on their previous observations was between 48% and 55%. For the renal CSC (which included renal medical wards and renal surgery), staff compliance with carrying out observations on time for patients who scored six or more on their previous observations was between 52% and 62%.

Records showed relevant consultants assessed most, though not all, patients admitted as an emergency within 14 hours of arrival at the hospital. Staff said meeting this standard had improved since the introduction of the new medical model and new working practices on AMU. This meant even if patients had not been allocated a bed on AMU or elsewhere in the hospital, consultants from AMU assessed and prescribed treatment plans for patients whilst they were still in the emergency department.
Staff in the endoscopy units followed processes to reduce risk to patients. They used a nationally recognised scoring tool to determine patients’ likelihood of bleeding past procedure. If a patient was identified as high risk of bleeding the procedure was carried out by a consultant endoscopist, rather than a nurse endoscopist. Throughout the procedure, a member of staff monitored the wellbeing of the patients, monitoring the patient’s vital signs to identify and act on any signs of deterioration. Staff followed the World Health Organisation (WHO) safety check list “Five Steps to Safer Surgery” to reduce risk to patients. The unit’s documentation audit for July to September 2017, showed staff audited all their documentation that supported safe care and treatment of patients. This included the safety check list. However, detail for this part of the audit was minimal, just detailing whether the check list was completed and whether it was signed. Results from this audit detailed the safety checklist was completed 90% of the time.

The cardiac day unit (CDU), used the WHO “Five Steps to Safer Surgery” checklist for patients undergoing cardiac procedures. The process was commenced at the patient’s bed side and carried though the cardiac catheter laboratory.

The trust had introduced a ‘SWARM’ process in some wards to support learning from and prevention of further patient falls. The ‘SWARM’ process was started by the NHS collaborative and was continued by the trust. A team that included a matron, nurse in charge of the ward, a practice educator, lead falls nurse, pharmacist (if required) supported the ward to review patient falls. The review process included checks that staff followed the unwitnessed falls policy, staff completed a post falls check list, the patient had a medical and medication review, staff identified risk factors and staff identified actions and followed them through. This had resulted in a reduction in injurious falls for two of the pilot wards, (G1 and AMU). The trust said they had also identified improved documentation and care planning in these two pilot areas.

**Nurse staffing**

Nursing and allied health care professional shortages increased the risk of patients receiving unsafe or inadequate care and treatment.

At the inspection of the urgent medical pathway carried out in February and May 2017, we identified a shortage of nurse staff in some wards and units with vacancies being filled by agency staff. However, at the time of that inspection the fill rate for agency staff meant wards and units were still not fully staffed. At this current inspection, we found a similar picture across the medical services.

The trust has reported their staffing numbers below for nursing staff from April 2017 to March 2018.

Fill rates ranged between 88.4% to 95.2% during the period. As of March 2018, there were 95.7 fewer whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
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<tr>
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<tr>
<td>May</td>
<td>856.3</td>
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</tr>
<tr>
<td>June</td>
<td>859.6</td>
<td>806.0</td>
<td>93.8%</td>
</tr>
<tr>
<td>July</td>
<td>860.9</td>
<td>801.9</td>
<td>93.1%</td>
</tr>
<tr>
<td>August</td>
<td>846.6</td>
<td>792.3</td>
<td>93.6%</td>
</tr>
<tr>
<td>Month</td>
<td>Vacancy Rate</td>
<td>Sick Rate</td>
<td>Turnover Rate</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>September</td>
<td>855.9</td>
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<tr>
<td>October</td>
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<td>November</td>
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<tr>
<td>December</td>
<td>864.0</td>
<td>764.1</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

(Source: Updated data from trust)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January to December 2017, the trust reported an annual vacancy rate of 19.4% for nursing staff in medicine. The trust did not have a target vacancy rate, but nursing staff had a higher vacancy rate than the trust total for all staff groups of 7.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January to December 2017, the trust reported a turnover rate of 17.3% for nursing staff in medicine. This is worse than the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a sickness rate of 4.4% for nursing staff in medicine. This is worse than the trust target of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

The trust identified four wards in medicine which had some of the highest uses of bank and agency staff at the trust. These are the medical assessment unit and wards F4, D3 and D2. It attributed this to a high vacancy rate and planned to mitigate this by recruiting substantive staff.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staff on many of the wards said staff shortages was one of their major challenges to delivering a safe service. They gave examples of how this affected the care of patients. Most staff described situations where on the occasions their ward was fully staffed, they were required to send a member of their staff to another ward where there were staffing shortages. Staff on the oncology and chemotherapy ward described the effect that reallocating their registered nurses to other wards had on their patients. They told us this depleted the number of staff who had the competency to administer chemotherapy medicines, which meant patients experienced delays in the administration of their chemotherapy treatments. We asked the trust for any information about the impact this had on patients receiving chemotherapy. The trust responded that there was no evidence that chemotherapy nurses have been moved from the wards.

Staff on F3 ward, a stroke rehabilitation ward, described they were almost consistently one band 5 nurse down on planned staffing levels for each shift. To ensure adequate numbers of staff were present, they had one extra band 2 health care assistant working. However, this did not give the
required skill mix to safely meet the needs of patients. Staff also described how low staffing levels meant training was frequently cancelled.

Staff in several wards said they believed patients received the care they needed, but staff shortages meant staff did not always fully record the care given to patients.

A member of the medical staff on AMU said that due to registered nurse shortages, nurses did not always complete their tasks in a timely manner. One nurse on AMU, describe the effect of not having sufficient staff stating that they could not do all the care, administer medicines and complete their administrative tasks in a timely manner. A second nurse on AMU described the emotional affect this had on some nurses. They described some nurses often leaving their shift in tears because they felt they had not been able to deliver a safe service.

Some patients commented on the shortage of nursing staff. One patient on the orange area of AMU described an incident when staff did not attend to their person hygiene needs and staff did not answer to call bells quickly, which they believed was due to staff shortages. On the red area of AMU, another patient commented that staff appeared very stretched to meet the needs of patients, which was why they believed they had not yet been offered anything to eat despite being on the ward for several hours.

A patient on the stroke ward said “can’t fault the nurses, can be short staffed. All others [patients] need hoisting which ties staff up. Sometimes staff get moved to another ward. Agency at night – don’t know you.” A patient of C6 ward said there were not enough nurses at night. They described an incident when they needed help. A health care assistant came to attend to them but the patient required a registered nurse to help them and they had to wait a length of time before one was available.

During our observations on AMU we noted nursing staff were challenged to carry out all their roles. In the orange area of AMU there was only one registered nurse and one health care assistant on duty. The registered nurse was very busy attending to the requests of medical staff who were attending to a clinically deteriorating patient, and fielding questions from distressed and angry relatives. In another area of AMU, there was also only one registered nurse and one health care assistant in the area. The registered nurse was speaking on the telephone. In both of those areas, the health care assistant was trying to attend to the needs of all the remaining patients.

At our inspection of the urgent medical pathway in February 2017, we found staff shortages on AMU meant there was not always a member of staff present in the allocated area for patients referred for assessment by their GPs. On 3 March 2017, we imposed a condition on the trust’s registration that required them to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced clinical staff in the corridor/waiting area of AMU and the GP triage area. At this current inspection, we found this situation had improved, and a member of nursing staff was always allocated to these areas. This meant patients referred to AMU by their GPs had their conditions monitored and escalated if needed, whist waiting for assessment by medical staff.

We reviewed the nurse staffing rotas provided by the trust for the medical wards which detailed the planned staffing levels for each ward and the actual number of staff who worked each shift. This showed that for the months of March and April 2018, for most wards, the actual number of staff who worked did not match the planned number of staff. Predominantly the shortages were in the registered nurse workforce. In some instances, the actual total numbers of staff met the planned number, but this was with a diluted skill mix, with less registered nurses and more health care assistants. Some examples of our findings from the review of the rotas is detailed below.
On G7, a renal medicine ward, the planned registered nurses staffing levels were six registered nurses on duty during the morning and afternoon shifts and five on duty at night. During March 2018 there were only 11 out of 31 morning shifts where there were six or more registered nurses on duty, nine out of 31 afternoon shifts where there were six or more registered nurses on duty and at night only 14 out of 31 shifts where there were five or more registered nurses on duty. For health care assistants the planned staffing numbers were three on the morning and afternoon shifts and two at night. The rota showed that there were only five out of 31 morning shifts where there were three or more health care assistants on duty, four out of 31 afternoon shifts where there were three or six more health care assistants on duty and at night only 15 out of 31 shifts where there were two or more health care assistants on duty. The April rota for G7 showed a similar picture for registered nurses, but a slightly improved picture for the number of health care assistants who worked.

On D3, a general medicine ward, the planned registered nurses staffing levels were six registered nurses on duty during the morning and afternoon shifts and four on duty at night. During March 2018 there was only one out of 31 morning shifts where there were six or more registered nurses on duty, and no afternoon shifts where there with six or more. At night only eight out of 31 shifts had four or more registered nurses on duty. For health care assistants the planned staffing numbers were four on the morning and afternoon shifts and two at night. The rota showed that the planned numbers were met or exceeded throughout March. The April rota for D3 showed a similar picture for both the number of registered nurses and health care assistants who worked the shifts.

On AMU the planned registered nurse staffing levels were 18 registered nurses on duty during the morning and afternoon shifts and 15 on duty at night. During March 2018 there were eight out of 31 morning shifts where there were 18 or more registered nurses on duty, six afternoon shifts where there were 18 registered nurses on duty and at night 21 out of 31 shifts where there were 18 or more registered nurses on duty. For health care assistants the planned staffing numbers were eight on the morning and afternoon shifts and seven at night. During March 2018 there were 19 of 31 morning shifts where there were eight or more health care assistants on duty, seventeen afternoon shifts where there were eight or more health care assistants on duty and at night 24 out of 31 shifts where there were seven or more health care assistants on duty. The April rota for AMU showed a similar picture for both the number of registered nurses and health care assistants who worked the shifts.

Staff knew what their planned staffing levels were, but did not offer any description about how this was calculated. The trust used the nationally recognised safer staffing tool to determine the required staffing levels for each ward or unit. However, when we discussed staff shortage with members of staff on the wards and units, no member of staff discussed the use of the safer staffing tool. This suggested the use of the tool was not embedded into the individual ward’s management of their staffing numbers.

To address staff shortages, the trust had started to ‘grow their own’ nursing staff. On the stroke rehabilitation ward one health care support worker had completed training to become a band 4 nursing associate and a health care support worker was in the process of undergoing training to become a band 4 nurse associate. The trust was also supporting two members of staff on the unit to complete nursing training through the Open University.

The speech and language therapist team leader said that the present establishment of speech and language therapists meant they could not meet the guidance that stroke patients should receive 45 minutes speech therapy five times per week. They explained they used a risk-based approach to determine which patients received therapy and the length of time of the therapy session. They
explained they had recently submitted a business case, and were waiting for the outcome, for recruitment of additional speech and language therapist to meet the national guidance.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm, and to provide the right care and treatment.

Inspection of the urgent medical pathway since 2016 identified there were insufficient numbers of medical staff in some areas to ensure patients received consistent safe care. At this current inspection, we found this situation had improved.

The trust has reported their staffing numbers below for medical staff from April 2017 to March 2018.

Fill rates ranged between 86.9% to 99.7% during the period. As of March 2018, there were 39.7 fewer whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>311.3</td>
<td>283.7</td>
<td>91.1%</td>
</tr>
<tr>
<td>May</td>
<td>309.9</td>
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<td>92.0%</td>
</tr>
<tr>
<td>June</td>
<td>308.8</td>
<td>281.4</td>
<td>91.1%</td>
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<tr>
<td>July</td>
<td>308.8</td>
<td>307.9</td>
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<tr>
<td>August</td>
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</tr>
<tr>
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</tr>
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<td>October</td>
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<td>November</td>
<td>302.8</td>
<td>274.0</td>
<td>90.5%</td>
</tr>
<tr>
<td>December</td>
<td>302.8</td>
<td>271.0</td>
<td>89.5%</td>
</tr>
</tbody>
</table>

*(Source: Updated data from trust)*

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January to December 2017, the trust reported a vacancy rate of 9.2% for medical staff in medicine. The trust did not have a target vacancy rate, but medical staff had a higher vacancy rate than the trust total for all staff groups of 7.3%.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January to December 2017, the trust reported a turnover rate of 6.5% for medical staff in medicine. This is better than the trust target of 10.0%.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
From December 2016 to November 2017, the trust reported a sickness rate of 0.9% for medical staff in medicine. This is better than the trust target of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

The trust identified four areas in medicine which had some of the highest uses of medical bank and agency staff at the trust. These were general medicine, Medicine for older people and rehabilitation services (MOPRS) junior medical staff, MOPRS senior medical staff and orthopaedics medical staff. The trust attributed this to vacancies and planned to mitigate this by recruiting substantive staff.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.
Staffing skill mix for the 269 whole time equivalent staff working in medicine at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/10/2017 - 31/10/2017)

Staff, both nursing, allied health professionals (AHPs) and medical that we spoke said there was sufficient numbers of medical staff on duty at any one time.

Since the previous inspection, the new medical model in AMU had been further embedded. There was consultant cover on the AMU from 8am to 10pm, seven days a week and the unit had introduced shift overlaps. This meant, to promote patient safety, medical staff had sufficient time to handover patients and ongoing work. A morning post take ward round had been reintroduced which included the night team junior doctor, ensuring effective handover of patients. Consultant medical staff on AMU told us that by having the facility to directly liaise with junior doctors, consultant productively had increased. Junior staff said medical staff cover in AMU was good and they had good support from the consultant team.

Consultants on AMU carried out a morning ‘post take’ ward round, followed by a rolling real time patient assessment process. The consultants also took part in two ‘board rounds’ during which they reviewed patient’s progress and treatment plans. This meant that national guidance that all patients in an AMU setting should be assessed twice a day by a consultant was met. Staff confirmed that on call consultants could access the hospital within 30 minutes when on call.

However, although most specialty consultants now committed to working with the new ways of working, which included the new medical model and the urgent care pathway, staff told us there were a few who chose not to contribute to the medical model. However, those consultants who chose not to take part allocated a locum consultant to carry out their role when they were rostered to be part of the medical model.

On the respiratory high care ward, there were three consultants who between them provided cover seven days a week. There was one registrar who was dedicated to high care who worked 8am to 5pm five days a week. All staff we spoke with said this was sufficient to meet the needs of patients.

The trust had six specialist stroke consultants who worked across the acute stroke ward, hyper acute stroke unit and the stroke rehabilitation ward. There were two dedicated senior house officer
posts for the stroke rehabilitation unit. However, at the time of the inspection one was on long term leave. The senior house officer working on the unit said support was provided from the medical team on the acute stroke ward located next door.

‘Buddy’ medical teams, ensured there was dedicated medical support for medical patients who were cared for on wards not related to their specialty need.

The hospital at night team covering the medical specialities consisted of a co-ordinating nurse practitioner, two registrars, two SHOs and three associate practitioners. The AMU held their own rota which included a registrar, three SHOs and one FY1. The renal team had their own night rota, which also provided the support to medical outlier patients.

We asked the trust to provided medical staff rotas for all medical service so we could confirm the staffing numbers and whether the actual staff worked met the planned staffing requirements. The trust responded that, “There will not be planned data as this is dependent on job planning per specialty and just sending numerous medical rotas would not provide meaningful data”

Records
Staff did not always have the complete information they needed before providing care, treatment and support.

During the inspection, we reviewed 48 patient records, which included medical records, nursing records and allied health professional records. There were gaps in most records, assessments were not completed and information in some records was conflicting.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about the management of records. However, inspections of the urgent medical pathway since 2016 identified staff working in the medical services did not ensure patients records were secure or that patient records were fully completed. Following our inspection in February and May 2017, we served a warning notice that required the trust to make significant improvements in regard of ensuring staff held patient records securely and that patient records were fully completed.

Each patient had a care pathway booklet, which included their care planning documents. Most care pathways were either three-day or seven-day care pathways. After three or seven days staff had to complete a new care pathway, which included duplication of work. The ward manager on C6 ward told us that they had recently audited how long it took to complete a patient care plan fully. They had identified it could take one nurse up to an hour to complete a full care plan, including all assessments and provide an informative personalised plan of care. They explained the reason why many care plans were not detailed, not personalised, had missing parts was because of the time it took to complete. This was compounded by the fact that care plans were required to be fully rewritten after seven days.

Our review of care pathways showed that for patients who had multiple care pathways due to a prolonged stay in hospital, subsequent care pathways had less detail in them. Staff on the stroke rehabilitation ward were trialling a new rehabilitation pathway that lasted either 16 days or 24 days. Staff on C5 ward said they had piloted a new care plan the week prior to our inspection. Feedback about the new care plan process was very positive with staff describing the plan as more comprehensive and easier to follow. Continuation after seven days required staff to reassess the patients care and only rewrite the care plan where needs had changed, rather than having to rewrite the whole care plan. Staff said there were also more prompts to assist staff remember to complete specific tasks e.g. catheter care checks and specific diets.
On G4 ward, we looked at records for five patients. There were gaps in three of the records. For one patient there was no detailed reason for admission and the pressure ulcer risk assessment was not completed. For a second patient there was no reason for admission, no moving and handling assessment, conflicting information as to whether the patient had a pressure ulcer and one entry on the 18 April 2018 was not signed for.

On D1 ward (an orthopaedic and trauma ward where medical outliers were cared for), we reviewed nursing care records for seven medical patients. We found gaps in the records for four of these patients. This included no entries in the intentional round records, no entries in fluid intake monitoring charts, no detail about the care and treatment of a pressure ulcer and no detail about how to reduce the risk of falls for a patient identified as at risk. For one patient who had diabetes, staff had not recorded in their care plan how their diabetes needed to be managed. Review of the patient’s observations showed that staff needed to take blood glucose readings before meals and before the patient went to bed. Between 13 and 18 May, the record showed staff did not record three before lunch readings and three before bed readings. The absence of this record meant it was not clear if these had occurred, or if needed, action had been taken to address.

On G1 ward we reviewed six sets of patients notes. For four of these patients, who staff said were subject to Deprivation of Liberty Safeguard authorisation, there was no associated documentation. For one patient whose white board detailed they required two hourly repositioning, records did not detail this was carried out.

On AMU we reviewed medical records for four patients. Medical notes were clear and organised, records of medical care were clear and legible, there was timely review by senior medical staff with clear management plans documented and the record the member of staff making the entry was identifiable. However, the patients or family’s viewpoint was only recorded in one the four plans and medical staff did not consistently record they had assessed the patient’s mental capacity to agree to admission.

For one patient in AMU nurses had not completed their falls prevention and assessment care plan. This patient had an intravenous infusion, for which there was no associated plan of care. For a second patient on AMU staff did not detail full instruction about how to support the patient safely with moving and handling tasks. Their continence care plan detailed they used continence aids (pads), but there was no description of the size of pad they used or how frequently the pad needed to be changed.

Review of a further two patient records for patients in AMU identified gaps or conflicting information in their records. This included lack of assessment for use of bed rails, despite bed rails being used, and for one patient whom staff said they gave medicines to covertly, no detail about this in their nursing or medical records.

On C6 ward we reviewed the records for one patient. This showed that although staff fully completed the initial pathway booklet, in subsequent pathway booklets they either did not fully complete or did not provide as much detail about how the patient’s needs should be met. In the hyper acute stoke unit, for the two patient records we looked we found staff had not fully completed the records.

For one patient on C5 ward, staff had not completed two pages of their care pathway booklet. For a second patient staff had not completed many of the patient’s admission assessments or the patient’s property list. For a patient on F3, staff had not ensured detail in the care plan followed the instructions recorded by speech and language therapist.
Assessments for some patients identified staff needed to monitor their food and fluid intake. However, many food recording charts were not fully completed. On E4 ward, a nurse led complex discharge unit, we found for two fluid charts we looked at there was no guidance about the amount of fluid the patient should have and staff had not totalled the patient’s fluid intake. From the information recorded, we were not assured that staff were accurately recording the patient’s fluid intake. For one patient their fluid charts detailed that for 17 April 2018 they had a total of 320ml up to midday and nothing recorded after that time, on 18 April 2018 a 400ml intake (only record was form 9am to 10am) and by 11.25am on 19 April 2018 there was no fluid intake recorded.

On D1 ward, for three patients whose assessments detailed they required staff to monitor their fluid intake, there were sporadic entries on their fluid charts, again providing no assurance that staff accurately monitored the patients’ fluid intake.

On C7 ward the information board above one patient’s bed detailed they required a ‘strict diabetic diet’. However, their nursing care plan detailed they took a normal diet. When we discussed this with the member of staff. They explained there was a mistake in the patient’s care records and the assessments and care plan should have detailed the patient was diabetic.

Patients assessed as requiring some assistance with eating their meals had their meals delivered on a red tray. This helped staff identify which patients needed assistance. However, care plans did not always detail the type and level of assistance patients required. This relied on staff’s personal knowledge and understanding of the patient’s needs.

For one patient in hyper acute stroke unit (HASU), their records evidenced on 11 April 2018 a dietician had seen them and prescribed a nasogastric feeding regime. There was no associated nursing care plan.

The trust carried out monthly audits of nursing care records. The trust provided the results for January, February and March 2018. The results showed that only two wards, F2 and F3, consistently met the trust target of 95% completion of care records. G3 ward met the target in February and March and D2 and G7 wards met the target once in the three months. All other ward areas failed to meet the trust target in any of the months. There was no evidence of any action plans to support improvements with completion of patient records.

The trust provided the results for the Health Quality Audit of medical records for 2017/18. However, the results were not broken down into the different medical services and there was no comparison to the previous year’s results. This meant we could not identify any trends in the completion of medical records.

We found multiple examples where staff did not store patient records securely. On E7 ward, staff had left unsupervised medical notes by a patient bedside. All wards we inspected had notes trolleys. However, most of these, although having lockable tops, were not locked and staff said they did not have keys to lock them. Many had open sections to the notes trolley where patient records were kept, making the records easily accessible to unauthorised persons. On G5 ward, the private patient ward, where medical outliers were cared for, we found a computer screen with patient details and x-rays was left open with no member of staff in attendance. On AMU, a patient’s discharge information was left lying by the printer. On F6 ward, the lockable notes trolley was left unlocked, despite CQC staff raising the issue with staff twice. On C5 ward, notes were held in an unlocked trolley in an open corridor.

On C6 ward, during our night-time visit, we observed notes trolleys were not secured and patient records were left out from notes trolleys. Due to the layout of the ward unauthorised persons could access the notes without being observed by a member of staff.
All wards had patient pathway boards. These were white boards that detailed the patient name, and included information such as whether they were subject to a deprivation of liberty safeguarding authorisation, what investigations, such as X-rays they were waiting for, and for some their planned discharge date and where they were being discharged to. Patients also had smaller white boards above their bed spaces where staff recorded the patient’s name and patient specific information such as dietary requirements, repositioning requirements and whether they were at risk of falls. This information on most wards, was fully visible to any person entering the ward, including members of the public. Patient care records included a section to detail whether patients gave their consent for their name and other details to be displayed on the white boards in public areas. However, these were not always completed. Following the inspection, we requested an impact assessment of the use of publicly visible patient journey boards from the trust. The trust replied they had not completed an impact assessment, but that patients consented to their details being displayed.

Staff followed processes to share information about patients care and treatment when they moved between different wards. Handover of patients between medical staff from AMU to the wards and between wards was predominantly completed electronically. Verbal handovers were only carried out for high-risk patients. Medical staff we spoke with said the electronic handovers provided all the medical information they needed to provide safe care and treatment. However, the electronic information and hand written medical notes did not always detail what information medical staff had discussed with patients and their families or the outcome of decisions about the ceiling of treatment for patients. This meant medical staff had to clarify with patients and their family members about their treatment escalation plan, the ceiling of treatment and what information they had been told by the medical staff previously treating them.

Medical staff working on AMU expressed their views about how the electronic systems supported safe care of patients. They said the two electronic systems, bed view used during day hours and nerve centre used during night hours, assisted with managing bed flow and referral process. However, there were times when the electronic patient recording systems did not support effective and safe management. For example, to complete assessments about patients risk of developing a venous thromboembolism (VTE) assessments a patient had to be admitted onto the trust’s electronic patient record, which did not happen until they were admitted as an inpatient. This meant VTE assessments and prescribing could not be carried out in the emergency department. Treatment against the preventing of VTEs did not start until the patient was admitted to the AMU.

Medical staff working on the AMU said systems for internal referrals to specialities such as gastroenterology, cardiology and respiratory medicine were effective. However, staff said referrals to other specialities varied in terms of ease of access, for example they often had difficulties contacting surgical and renal teams by their bleeps and there was confusion around the bleep holder roles. However, staff did not provide evidence where there had been delays in patient treatment due to these difficulties.

**Medicines**

Staff did not always follow best practice guidelines for storing and recording medicines

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about the management of medicines. However, inspections of the urgent medical pathway since 2016 identified staff working in the medical services did not always ensure they followed safe medicines management processes. Inspections in February and March 2016 and February and May 2017 identified staff did not always securely store medicines.
Inspections in September 2016 and February and May 2017 identified the service did not achieve the trust target for medicines reconciliation within 24 hours of admission to the hospital. Our inspection in September 2016 and February and May 2017 identified staff did not ensure medicine fridges were working at the recommended temperatures to ensure medicines were not adversely affected. Following our inspection in February and May 2017 we served a warning notice on the trust that required them to make significant improvements with the safe management of medicines.

During this current inspection we found most staff stored medicines securely. However, we found some isolated incidents where staff did not store medicines securely on the ward. On D1 ward, (an orthopaedic and trauma ward where medical outliers were cared for) we found intravenous paracetamol on the work surface in the clean utility room, not locked in the medicines cupboard. On F2 ward, we found, staff left the medicines trolley and fluid cupboards unlocked. The fluid cupboard door was open, so unauthorised persons could easily access the intravenous fluids that were stored in there. During the evening/night inspection of medical services we found medicines for injection situated on open work surfaces, rather than staff locking them away in a secure area.

In some areas, we found out of date medicines stored on the wards. On C7 ward, staff stored antibiotics that were out of date. On AMU, we found medicines that were past their use by date and an insulin pen that did not have a label on it to determine whose pen it was.

Most staff checked and recorded temperatures for the fridges storing medicines daily. However, we found concerns with the records on some wards. On D1 ward, staff recorded the temperature range as going above the maximum temperature for the month of April leading up the inspection. In March, records showed staff did not check the fridge temperature daily and again staff recorded the maximum temperature as above the recommended temperature. There was no record that staff had taken any action to rectify this or to seek assurance the medicines were stored at correct temperatures. Records of G4 ward, C7 ward, and F2 ward all showed occurrences when staff recorded medicine fridge temperatures as above the recommended temperature with no evidence that staff had acted to rectify this. Staff on the wards said they reported the out of range fridge temperatures to the maintenance team, but they did not record this and there was no evidence any action had been taken.

There were systems in place to reduce delays with medicines for patients to take home with them. These included near patient dispensing points, independent pharmacist prescribers, occasional use of FP10 prescriptions and discharge planning which included the pharmacy team.

Since the last inspection nurses had received training updates about administering medicines covertly so that this could be done safely if needed. We saw information that had been supplied by the pharmacy department and nurses described a safety huddle where this had been discussed. However, conversation with one member of staff indicated that not all staff had a good understanding and could recognise whether medicines were being administered covertly. A member of staff on AMU told us that one patient was having their medicines administered covertly, as a liquid in their drinks. The trust stated this patient was having their medicines administered covertly, in a liquid form, as this followed the care provided to the patient by staff at the patient’s care home. There was no associated care plan to support this practice and the member of staff did not know whether the pharmacist had been involved in the decision to administer medicines in this way.

Suitable emergency medicines were regularly checked, stored appropriately and available for use. Pharmacy staff, nurses and doctors were involved in medicines reconciliation on admission and discussed medicines with patients. The trust carried out medicine reconciliation audits and had a
trust standard that a minimum of 80% of medicines reconciliation should be completed within 24 hours of admission. Results of the audits provided to use by the pharmacy department were trust wide, so we could not identify how medical services were performing against this standard. The audit showed improvements from January 2018 when only 76% of patients had a medicines reconciliation carried out within 24 hours of admission. In February 2018 this figure was 80%, but in March 2017 was 81%. The audits identified medicine reconciliation was not carried out in a timely manner for patients admitted at weekends. This was attributed to the fact there were no ward based pharmacists at weekend. The trust did not advise us of any action they were taking to improve the medicine reconciliation rates for patients admitted to the hospital at weekends.

Patients were kept informed about any changes to their medicines and were prepared for leaving the hospital. Some patients showed us a ‘green card’ they had been given with their medicines and instructions listed to help them. However, a few patients said staff had not given them a full explanation of what their medicines were for.

Insulin was prescribed on a separate medicine chart and patients were given, or supported to give their own insulin at appropriate times. This was recorded on the charts.

Patient were encouraged to bring their own medicines with them on admission for familiarity and patient concordance with medicines. On occasions patient’s own medicines were used to avoid delay in administration if it was safe to do so. However, on occasions relatives were asked to bring medicines in after admission and this lead to delays in patients receiving their medicines.

The pharmacy kept three secure ‘escalation’ drug trolleys which could be sent to any department which had temporary beds. These contained medicines that might be needed in these situations.

The pharmacy team was embedded on the wards (except at weekends) and provided clinical advice, support to patients, training and medicines supply.

Antimicrobials were prescribed on the standard medicine chart. However, there was no space on the chart to record a review date as recommended in Public Health England guidelines for hospitals ‘Start Smart then Focus’. Clinical staff we spoke with knew of the importance of reviewing antimicrobial prescriptions but this was not recorded on the chart or any follow up noted. A new medicines chart for prescribing Gentamicin had been developed to ensure that blood tests were taken correctly and doses adjusted appropriately.

The indication for medicines prescribed ‘prn’ (when required) were not recorded on the medicine charts we looked at. The trust policy states that this should be the case and this was backed up with training for junior doctors; however, we did not see evidence of this in practice.

We saw medicines being prepared and given safely. However, on one ward we observed a nurse interrupting people’s meals to administer medicines. This can lead to people refusing their medicines or not completing their meal. Associate practitioners had been trained to administer some medicines. This had freed up nursing time to concentrate on more complex tasks.

On AMU we observed an incident that suggested medicines might not always be delivered to or received by appropriate members of staff. A pharmacy technician tried to deliver medicines to a CQC inspector and repeatedly to a health care assistant, despite the health care assistant informing the pharmacy technician that they were not qualified to receive medicines. We also observed that medicines for a patient to take home were left on the desk in the middle of the ward unattended for up to 20 minutes, before they were given to the patient.
Incidents

Safety concerns, such as staff shortages, were not always reported as an incident. Shared learning from incidents was not fully established.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about their management of incidents. However, inspections of the urgent medical pathway since 2016 identified staff did not report all incidents and that for incidents they did report, they did not grade the incidents correctly. At that time, staff carrying out root cause analysis of incidents had not received training to equip them with the necessary skills to carry out the role. Following our inspection in February and May 2017, we served a warning notice that required the trust to make significant improvements regarding the reporting and investigation of incidents. At this current inspection we found some improvements had been made to the management of incidents, but further improvements were still needed.

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From February 2017 to January 2018, the trust reported two incidents classified as never events for medicine. Both incidents took place at Queen Alexandra Hospital and were classed as surgical/invasive procedure incidents meeting serious incident criteria. These were:

- Insertion of central venous catheter (CVC) on the ward into patient's right internal jugular vein (October 2017)
- Wrong stent placed in biliary tree causing pancreatitis (January 2018)

*Source: NHS Improvement - STEIS (01/02/2017 - 31/01/2018)*

Review of the root cause analysis (RCA) from these two events, showed a common factor of lack of use of safety checks and Local Safety Standards for Invasive Procedures (LocSSIPs). Action plans for both RCAs included, amongst several actions, the development and use of LocSSIPs for both these procedures. There was evidence the learning from these incidents was share trust wide and that duty of candour processes were followed. In response to the outcomes of the RCAs plans were developed, that included actions to be taken, the member of staff responsible for the action and when the action was due to be completed by. Our review of the action plans showed, some actions were completed and others were still in progress, but none had exceeded the planned timeline for completion. As part of our ongoing monitoring of the trust, the trust had informed us that root cause analysis training had been provided to members of staff who carried out these investigations. Review of the two RCA for the never events, showed investigations followed a structured process to identify possible causes and learning from the incidents.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 54 serious incidents (SIs) in medicine at Queen Alexandra Hospital which met the reporting criteria set by NHS England from February 2017 to January 2018.
These were:

- Slips/trips/falls meeting SI criteria with 18 (33% of total incidents).
- Pressure ulcer meeting SI criteria with 15 (28% of total incidents).
- Abuse/alleged abuse of adult patient by staff with five (9% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with four (7% of total incidents).
- HCAI/Infection control incident meeting SI criteria with three (6% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (6% of total incidents).
- Incidents pending review with three (6% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (2% of total incidents).
- Environmental incident meeting SI criteria with one (2% of total incidents).
- Substance misuse whilst inpatient meeting SI criteria with one (2% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Staff reported incidents through the trusts electronic incident reporting process. Staff said they would recognise a safety incident, and described situations when they had reported incidents. We saw several examples during the inspection process where staff completed incident reports, for example for patient falls. One of the concerns identified at previous inspection, was that staff did not report staff shortages as incidents. Review of incidents reported via the NHS National Reporting and Learning System (NRLS) and STEIS showed that this was still the case.

Staff received confirmation they had submitted incident reports. There was mixed experience of receiving feedback from reported incidents. Some staff gave examples of shared learning form incidents in their own ward and across the trust. However, other staff commented that although they received feedback about incidents that occurred in their local area of work, they rarely had feedback and shared learning from incidents that originated in other areas of the trust.

Regulation 20, Duty of Candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient, and to provide support when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff had a clear understanding about the Duty of Candour legislation and gave examples where the Duty of Candour process was followed, with patients and their family members involved in the investigation process and verbal and written apologies being provided to the patient. We saw copies of the route cause analysis reports of never events and written apologies were sent to the patient and their families.

The different Clinical Service Centres (CSC) held monthly mortality and morbidity reviews. We reviewed records of these. Each CSC documented the process differently, but for most, there was evidence of learning and action to be taken forward following the review. For others there were
details of questions and discussion points at the meeting, but no record of the discussion that took place or actions taken forward because of the meeting. Records of the mortality and morbidity meetings evidenced the requirement to follow Duty of Candour processes was considered as part of the review of deaths.

It was not clear how frequently medical staff reported incidents. One junior medical staff told us that in the two years they had worked at the trust they had never made an incident report, but had received feedback and learning from other incidents.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 52 new pressure ulcers, 34 falls with harm and 27 new catheter urinary tract infections in medical care from December 2016 to December 2017.

Since September 2017 there has been a decrease in the rate of falls with harm and new catheter urinary tract infections. The rate of new pressure ulcers had remained fairly constant (from July to November 2017) but has increased from November to December 2017.

*Source: Safety thermometer - Safety Thermometer*
It was not evident that all wards used results from the safety thermometer to bring about improvements to the service they delivered.

On C7 ward some staff spoke about a monthly ‘safety thermometer’ audit, but other staff had no knowledge about the safety thermometer. Staff on D1 (an orthopaedic and trauma ward who had medical outliers) completed the safety thermometer monthly, which included detail about pressure ulcers, falls, VTE and infections. However, it was not evident how they used this information to improve the service they delivered.

Most wards had performance boards where information gathered from safety thermometer results was displayed. This meant both staff, visitors and patients were informed about the performance of the ward. Some wards performance boards included information about the action staff were taking in response to the safety thermometer findings. However, staff on C7 ward said that results from safety thermometer data collection were shared with staff, but not displayed. This meant the information was not shared with patients or visitors.
Is the service effective?

Evidence-based care and treatment

Care and treatment did not always reflect current evidence based guidance or best practice standards.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about patients receiving evidenced-based care and treatment. However, our inspection of the urgent care pathway in September 2016 identified records failed to demonstrate staff always followed evidence based guidelines. Our inspection of the urgent medical pathway in February and May 2017 identified staff did not always follow national guidance about provision of nutritional support, including naso gastric (NG) tube feeding. At this current inspection we found a similar picture.

Medical services had pathways and protocols for a range of conditions, which took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, for heart failure, stroke, diabetes, respiratory conditions, falls prevention, pressure ulcer prevention and sepsis. However, on AMU there was lack of clarity where staff could find the evidenced based protocols and guidance to support their delivery of evidence based care and treatment.

Poor completion of patient records, meant the service did not have full assurance staff always followed evidence based pathways and guidance. For example, records showed staff did not check the position of patients NG tubes, staff did not always complete assessments, staff did not always administer antibiotics within time scales set by national guidance for patients with suspected sepsis and trust audits showed staff did not always follow the national Early Warning Score (EWS) guidance to monitor patients at risk of deterioration.

The endoscopy units (both at Queen Alexandra hospital and Gosport War Memorial hospital) have received accreditation from the Joint Advisory Group (JAG). JAG is a quality improvement and service accreditation programme for gastrointetinal endoscopy. They assess endoscopy units to monitor whether they meet and maintain the JAG quality standards. This meant the endoscopy unit met the national guidance for delivering an endoscopy service, which included routine auditing of the service provided.

The hospital used the national cancer intelligence network chemotherapy protocols, based on NICE guidance. Nurse practitioners used the UK Oncology Network triage tool to carry out telephone triage of patients calling for support and advice.

In line with national guidelines, patient records on the Acute Medical Unit (AMU) showed they were seen and reviewed by a consultant twice daily. Once transferred to general ward, records showed, in line with national guidelines, most patients were reviewed during a consultant led ward round once every 24 hours. The change of medical staff rotas and embedding of the medical model had resulted in improved compliance with meeting the national guideline that patients should be assessed by a consultant within 14 hours of emergency admission to hospital.

The hospital’s stroke service worked towards meeting the Sentinel Stroke National Audit Programme (SSNAP) standards. However, speech and language therapy staff could not meet the required 45 minutes of therapy five days a week, because of insufficient numbers of therapy staff.

Nutrition and hydration

Staff did not fully consider patients nutritional and hydration needs.
At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about managing the nutrition and hydration of patients. However, inspections of the urgent medical pathway since 2016 identified differing concerns with how staff ensured patients had enough food and drink to meet their needs.

Patients had assessments of their nutritional and dietetic needs on admission using a nationally recognised tool. However, for patients who staff identified as needing fluid and nutritional monitoring, the assessments provided little information about their usual or required nutritional and fluid intake or the support they needed.

Staff referred patients to dieticians for dietetic support if their assessments indicated the need. Staff referred patients identified at risk due to swallowing difficulties to speech and language therapists. However, lack of numbers of speech and language therapists meant there was a risk of delay of support for such patients.

We saw staff on the stroke unit assisted patients at meal times if additional help was required.

**Pain relief**

Staff did not fully consider pain patients might be experiencing.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about managing the nutrition and hydration of patients. At our inspection of the urgent medical pathway in February and May 2017, we identified staff did not use any tools to support their monitoring pain in patients who had cognitive impairment or communication difficulties. At this current inspection, we found this situation was unchanged. Staff used a numerical score measure pain experienced by patients which they recorded on the trust electronic patient monitoring system. If a patient was unable to communicate verbally, for example a stroke patient or someone with advanced dementia, medical, therapy and nursing staff considered the patient’s body language to determine the level of pain they were experiencing. Nursing staff also said they relied on asking patients family members whether they thought their relative was experiencing pain. There was no evidence that staff used nationally recognised tools such as the Disability Distress Assessment tool (DisDAT) to help identify pain in people with severe communication difficulties or the Abbey Pain Score for people with dementia.

Most patients we had conversations with told us their pain was well controlled, they received pain-relieving medicine when they requested it. We observed nursing staff administered additional pain relief to patients, when patients requested it.

Pain relief in the endoscopy unit was well managed. Staff prescribed and administered appropriate pain relief and spasm relieving medicines.
Patient outcomes

Information about clinical outcomes was collected and monitored. The information was used to improve care.

Relative risk of readmission

Queen Alexandra Hospital

From November 2016 to October 2017, patients at Queen Alexandra Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Queen Alexandra Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a similar to expected risk of readmission for elective admissions
- Patients in nephrology had a higher than expected risk of readmission for elective admissions

Non-Elective Admissions - Queen Alexandra Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine and nephrology had lower than expected risk of readmission for non-elective admissions
- Patients in medical oncology had a similar to expected risk of readmission for non-elective admissions

Sentinel Stroke National Audit Programme (SSNAP)

Queen Alexandra Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D in latest audit, April to July 2017. This is a deterioration from grade C achieved in the audit the previous quarter and grade B achieved in the quarter before that.
The trust performed well, gaining a Band A, for case ascertainment, audit compliance and its discharge process but was graded Band E, the lowest, for its stroke unit. It also performed poorly for specialist assessments, speech and language therapy and multi-disciplinary team working.

**Queen Alexandra Hospital**

### Patient centred Performance

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<th>Domain</th>
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<th>Apr-Jul 16</th>
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### Team centred Performance

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<td>B↑</td>
<td>C↓</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>C↑↑</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred Total Key Indicator Level</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
</tbody>
</table>
The trust provided us with their action plans in response to the latest SSNAP audit which detailed the actions they were taking to improve the service for patients and future audit results. This included action such as training nursing staff to carry out swallow assessments and submitting a business case to increase the number of speech and language therapists employed to achieve the 24-hour target for patients receiving a swallowing assessment and the 72-hour target for patients receiving a speech and language therapist assessment.

The community stroke rehabilitation team, which was part of the Medicine for Older Persons and Rehabilitation Services CSC, also submitted data to the SSNAP audit. SSNAP set a target that 40% of stroke patients should have an early supported discharge. As a result of cohesive working between the inpatient stroke wards and the community stroke rehabilitation team, 60% of patients at Queen Alexandra Hospital had an early supported discharge. The effectiveness of the community stroke rehabilitation team had significantly contributed to the trust’s constant A rating since January 2016 for discharge processes.

Heart Failure Audit

In-hospital Care Scores
Results for Portsmouth Hospitals NHS Trust in the 2016 Heart Failure Audit were better than the England and Wales averages for all of the four of the standards relating to in-hospital care.
Results for Portsmouth Hospitals NHS Trust results were better than the England and Wales averages for seven of the nine standards relating to discharge.

The trust had developed an action plan in response to the audit findings which detailed the actions they were taking to improve the service for patients and results in future audits.

**National Diabetes Inpatient Audit**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2018 National Diabetes Inpatient Audit identified 188 inpatients with diabetes at Queen Alexandra Hospital, 91.5% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 4.

The trust generally performed well in the audit although was in the worst performing quartile for glucose management errors, insulin errors and medication errors.

(Source: NHS Digital)

Following the inspection, we asked the service to provide any action plans they had developed in response to the findings of the audit. They provided a record of a Diabetes Team Meeting held 21 March 2018 in which they discussed the findings from the 2017 audit, but not the findings from the 2018 audit as detailed above. The record suggested areas for improvement, but there was no detail about when an action plan would be finalised.

**Myocardial Ischaemia National Audit Project (MINAP)**
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 98.5% of nSTEMI patients were admitted to a cardiac unit or ward at Queen Alexandra Hospital and 100% were seen by a cardiologist or member of the team compared to an England average of 96.2% and 55.8%.

The proportion of nSTEMI patients who were referred for or had angiography at Queen Alexandra Hospital was 85.2% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Following the inspection, we asked the service to provide any action plans they had developed in response to the findings of the audit. The action plan detailed the service was continuing to provide education to paramedic staff from the two local NHS ambulance trusts, as the service had identified the main barrier to consistently achieving targets for timely treatment was delays in ambulance conveyance.

**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.9%, which does not meet the audit minimum standard of 90%. The 2016 figure was 51.3%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 10.6%, this is a negative outlier. The 2016 figure was significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 46.7%, this is a negative outlier. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 53.8%, this is worse than expected. The 2016 figure was not significantly different from the national level.

The one year relative survival rate for the trust in 2017 is 34.7% which is within the expected range.

(Source: National Lung Cancer Audit)

The trust had developed an action plan in response to the audit findings which detailed the actions they were taking to improve the service for patients and results in future audits.

**National Audit of Inpatient Falls 2017**

The trust had a multi-disciplinary working group for falls prevention where data on falls were discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 88%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 41%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 81%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 85%. This did not meet the national aspirational standard of 100%.
The trust had developed an action plan in response to the audit findings, which detailed the actions staff were taking to reduce the number and the affect falls had on patients. Some of the actions included staff piloting a new falls assessment tool, planned implementation of a new falls care plan, ongoing falls prevention training for all staff, and collaborative working to reduce the number of falls across the trust.

The Phoenix Rehabilitation centre (F1 ward) was a member of the UK Rehabilitation Outcomes Collaborative (UKROC). Data submitted to UKROC was analysed nationally and fed back to each service in the UKROC. The data allowed comparison of outcomes with other similar rehabilitation units. The most recent data, (December 2017) showed the Phoenix Rehabilitation Unit performed better than similar rehabilitation units for length of stay, referral to admission times and better for physical motor gains for patients. They performed similar for patient's cognitive gains.

The trust performed poorly in the National Audit of Dementia Care in General Hospitals carried out by the Royal College of Psychiatrists in 2016/17. They were the second worst performing hospital for carers rating of patient care (147 out of 148), the fifth worst performing hospital for communication with carers (143 out of 148) and the tenth worst performing hospital for discharge planning (189 out of 199). The trust had an action plan that detailed the actions they were taking to improve the service they provided to patients with dementia. This included addressing staff concerns regarding their ability to care for patients with dementia and the lack of a specialist team to support staff/ patients who need help, addressing carers concerns about communication, addressing the findings that the ‘This is Me’ document was not used routinely and that patient records did not evidence patients and carers were involved in discharge planning.

Following the inspection, we asked the trust to submit information about audits carried out in the medical services and any associated action plans to evidence they acted in response to audit findings. The trust provided the annual audit cycle for all medical services. This showed all medical services took part in a mix of national and local audit activity. However, apart from the action plan detailed above the trust did not provide any outcomes or action plans from the audits.

**Competent staff**

There were gaps in management and support arrangements for staff such as appraisal, supervision and professional development.

Comprehensive inspection of medical services in 2015 and inspections of the urgent medical pathway since 2016, identified that services involved in the pathway consistently failed to meet the trusts target for staff having an annual appraisal. We had previously served requirement notices on the trust regarding this failure.

**Appraisal rates**

From April 2017 to March 2018, 69% of staff within medicine at the trust had received an appraisal which failed to meet the trust target of 85%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>302</td>
<td>294</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific,</td>
<td>42</td>
<td>31</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff was the only staff group which achieved the 85% target for appraisals. *(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

Data provided by the trust following the inspection showed that out of the medical services only nursing staff working on four of the medical wards, nursing staff working in the endoscopy unit and some of the specialist nurse groups had achieved the trust target of 85% of staff completing an annual appraisal.

Comparison to the previous inspection reports and updated data provided by the trust, showed a picture of declining compliance for nursing staff working in AMU receiving an annual appraisal. The report of the inspection in September 2016 detailed nurse appraisal rate for AMU as 75-77%. The report of the inspection in February and May 2017 detailed AMU nurse appraisal rate as 68%. At this inspection, the updated data provided by the trust showed the AMU nurse appraisal rate had dropped to 41%. Appraisal rates for nurses working in the medicine clinical centre (CSC) was slightly improved (63%) from the 2017 report (62%), but remained significantly below the trusts target of 85%. The trust reported 0% of nursing staff working on E8 ward had an appraisal in the preceding 12 months.

Medical staff, except for both junior and senior medical staff working in elderly health services, had met the 85% target.

Medical staff confirmed they received formal supervision. However, formal supervision did not regularly happen for nursing staff.

The trust required all new members of staff to complete induction training when they started working for the trust. We saw records that evidenced staff had completed induction training. Nurses and Allied Health Professionals confirmed they had completed induction training. This included trust induction and local induction to the area they worked in. Bank and agency nursing staff completed a short induction to the trust and the area they were working in. Wards held copies of completed induction checklists for bank and agency nurses. This provided assurance to ward staff, that all staff had been inducted to the area they were working in.

Staff completed competency assessments relevant to the area they worked in. Some areas had developed their own in-house training specific to the needs of their specialty. For example, cardiac high care had developed cardiology courses that their nurses completed.

All wards displayed education information. This included available dates for training and updated information about certain topics such as management of sepsis, ECGs, pressure ulcer care, falls prevention and nurse revalidation.

On the stroke rehabilitation unit, (F3), due to staffing levels, the ward could not offer staff training to support professional development. The ward manager said there was no time or capacity to enable staff to attend training to gain additional skills which included o sending staff on cannulation
courses. However, all staff completed the Stroke Training and Awareness Resources (STARS) core competencies. Senior members of staff completed advanced STAR modules.

Staff on the oncology and chemotherapy wards completed the Wessex Cancer Network chemotherapy course to ensure they had the appropriate skills and competencies to care for their patients.

All nursing staff across the respiratory ward and respiratory high care completed a three-month training programme covering all aspects of respiratory high care, including assessment of competencies. This meant that nursing staff on the respiratory ward could manage sick respiratory patients on the ward before they needed high care treatment and potentially avert an admission to high care. A respiratory training programme was being developed for health care assistants to complete.

Most medical staff on the AMU confirmed the work rota enabled them to attend all planned teaching sessions. However, some medical staff told us there was no ‘bleep protection’ during the teaching session. This meant they could be called out of the teaching session to attend to clinical duties. There were three one-hour teaching sessions on Tuesday, Thursday and Friday. All junior medical staff, including non-training grade doctors were allocated educational supervisors.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about multidisciplinary working. However, inspections of the urgent medical pathway in September 2016 and February and May 2017 identified multidisciplinary working was not fully embedded in all areas of the medical services. At this current inspection we found medical services had made some improvements with multidisciplinary working.

Previously in AMU, there had been lack of multidisciplinary working between nursing and medical staff and a lack of involvement of the multidisciplinary team in planning care and treatment for patients. Since those inspections, staff told us there had been improvements with how the nursing and medical teams worked together. Band 7 nurses now attended consultant meetings, this had not previously happened. The lead AMU consultant spoke positively about the enthusiasm and energy of the nursing staff, who were identifying ideas and solutions to some of the problems experienced by AMU. AMU had introduced the practice of daily safety huddles, which included the complete multidisciplinary team. This provided an opportunity for the whole team to discuss and plan the care and treatment for vulnerable patients.

At the inspection in September 2016 and February and May 2017, there was no process to ensure medical patients cared for on outlying wards had their therapy needs met. Since that time processes had been put in place to ensure patients cared for on outlying wards continue to have access to the full multidisciplinary team members they needed as part of their ongoing care and treatment.

Multidisciplinary team working was fully established in the stroke wards. Staff on the hyper acute stroke unit and the stroke rehabilitation ward followed a fully integrated care pathway, with all staff following an integrated care pathway. The stroke rehabilitation ward held multidisciplinary team meetings every Thursday during which they discussed every patient’s plan following which the nursing staff prescribed the weekly plan for patients. The lead occupational therapist who worked on the stroke rehabilitation ward commented that multidisciplinary team working with other therapists, medical staff and nursing staff had significantly improved.
The community stroke rehabilitation team was an integrated team consisting of registered nurses, health care assistants, occupational therapists and physiotherapists. This meant the service pooled their resources, shared learning and allocated the most appropriate member of staff to patients. The community stroke rehabilitation team also worked with the local voluntary sector to provide support to patients, for example the local stroke clubs.

The respiratory high care ward provided an ‘ad hoc’ outreach service to ward patients who had non-invasive ventilation needs, or to those who were admitted who had home non-invasive ventilation. Both nursing and medical staff, reported there was effective multidisciplinary team working on the respiratory high care, and all staff could and did challenge the decisions of consultants is they had concerns. They described good links with the critical care team and could access support and beds in the critical care unit if the patients required invasive ventilation.

Services had access to two mental health liaison teams. The adult mental health liaison team provided an 8am to 11pm, seven-day week service to the emergency department and AMU. The older persons mental health liaison team provided a service for patients with dementia over the age of 65 across all wards seven days a week. At night the service had to rely on telephone support from mental health crisis teams.

Information for patients with a mental health diagnosis was shared, where appropriate, with local mental health teams, social care and domiciliary support agencies. How this was sometimes difficult due to differences in record keeping between the different providers for example, local mental health services were provided by three separate NHS mental health trusts who each used a different electronic record system with Portsmouth hospitals NHS trust using paper records or a fourth electronic records system.

**Seven-day services**

The service was working towards delivering a full seven-day service.

The NHS seven-day services programme is a set of 10 clinical standards, four identified as priorities, to ensure patients admitted to hospital as an emergency receive high quality and consistent care whatever time of day they enter hospital. NHS England requires trusts to carry out surveys to measure their performance against the four priority standards. We were not able to assess whether medical services carried out these as we did not ask for them.

Priority clinical standard 2 requires trusts to ensure all patients admitted as an emergency to be assessed by a consultant with 14 hours of arrival at the hospital. Our review of patient records, discussions with staff and patients, showed most patients, admitted as an emergency, had a consultant review within 14 hours of arrival at the hospital.

Priority clinical standard 5 requires trusts to ensure all inpatients to have scheduled seven-day access to diagnostic services, such as ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. This standard also dictates timescale for reporting on diagnostic tests. Our review of records and discussions with staff showed that most of these services were available seven days a week. Routine endoscopy services at weekends were subcontracted to another provider. Emergency endoscopy procedures at weekends were carried out in theatres by the gastroenterology consultants. Review of the Clinical Service Centre’s quality and governance meeting records and risk registers showed there was no local access to cardiology MRI scanning. Patients who required this service had to be transferred to another acute NHS trust.
Priority clinical standard 6 requires trusts to ensure inpatients to have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. Staff reported patients, when required, could access most consultant led interventions 12 hours a day, seven days a week. Stroke patients who required urgent thrombectomy procedures, were referred and transferred to a nearby acute NHS trust for this treatment. However, that trust did to yet provide this as a 24-hour service.

Priority clinical standard 8 requires trusts to ensure all patients with high dependency needs are seen and reviewed by a consultant twice daily and other inpatients are seen and reviewed by a consultant at least once every 24 hours. Our review of patient records consultants reviewed most but not all patients once every 24 hours.

In the AMU, there was a consultant on site 14 hours a day, which met the Royal College of Physicians guidelines. Outside these hours, there was a medical consultant on call who could reach the hospital within 30 minutes.

The Community Stroke Rehabilitation Team (CSRT) who were part of the Medicine for Older People and Rehabilitation Services (MOPRS) CSC, provided a seven-day service to the trust’s stroke patients in the community.

All stroke wards had seven-day physiotherapy service, but not a seven-day occupational therapy service. However, there was a consultation process taking place about the plan to implement seven-day occupational therapy working for the stroke rehabilitation service.

There was pharmacy provision across the service seven days a week, but this was not ward based at the weekends or bank holidays.

**Health promotion**

There was some focus on prevention and early identification of health needs and staff were not proactive in supporting people to live healthier lives.

Most wards had information boards and information leaflets that signposted patients and relatives to support services, that would provide health promotion information.

Specialist nurses, such as heart failure and cardiac rehabilitation nurses, promoted healthy living as well as supporting patients to manage their own health needs.

However, it was not evident during the inspection, through discussions with patients and review of care records, that health promotion was embedded into the running of wards.

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

Consent to care and treatment was not obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about staff understanding an application of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS). However, inspection of the urgent care pathway in September 2016 and February and May 2017 identified not all staff had a full understanding about their roles and responsibilities towards the Mental Capacity Act 2005 and DoLS. Following our inspection in February and May 2017, we served a warning notice on the trust that required them to make significant improvements about staff understanding and the application in practice of the Mental Capacity Act 2005 and associated DoLS.
The trust set a target of 85% for completion of Mental Capacity Act and DoLS training. A breakdown of compliance for Mental Capacity Act and DoLS courses from April 2017 to January 2018 for medical and dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>265</td>
<td>294</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>263</td>
<td>294</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>108</td>
<td>169</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>104</td>
<td>167</td>
<td>62%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff met the trust training target for DoLS intro and MCA Level 1 but not for the two more advanced courses.

A breakdown of compliance for MCA and DoLS courses from April 2017 to January 2018 for nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>726</td>
<td>751</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>726</td>
<td>751</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>423</td>
<td>491</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>587</td>
<td>683</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff met the trust training target for all MCA and DoLS modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff awareness and understanding of their responsibilities towards the Mental Capacity Act (MCA) and associated Deprivation of Liberty Safeguards (DoLS) was variable. Although nursing staff, in conversations demonstrated an understanding about the MCA and associated DoLS, their practices did not fully evidence they understood their individual responsibilities towards the MCA and associated DoLS. Staff said that although they completed training about the Mental Capacity Act and associated DoLS, they felt the training was limited and did not provide them with the appropriate skills to care for patients. Nursing staff lacked awareness of their responsibilities under the Mental Capacity Act. There was a culture of nursing staff believing mental capacity assessment and consent was not a concern for nurses and a reliance on medical staff to complete appropriate forms and make decisions about patient consent and capacity.

We asked nursing staff across the wards and units about when and how they carried out mental capacity assessments. Most nursing staff replied it was the role of medical staff (consultants and registrars) to carry out mental capacity assessments, not a role that nurses carried out. When we probed further and asked clinical leads about this, it became evident the trust had placed emphasis on identifying patients who did not have capacity to make decisions about their
discharge and place of discharge or about their continued admission to and treatment in hospital and thus required a DoLS application. The trust policy was that for DoLS applications, medical staff had to carry out the assessment to determine whether the patient had capacity to make the specific decision or not. During board rounds, medical staff discussed which patients may or may not have capacity to make decisions and identified those patients that probably had reduced capacity and needed an application of a DoLS authorisation. During our discussions with clinical leads, they suggested the emphasis of medical staff making decisions on board rounds about patients’ capacity and DoLS applications had resulted in nursing staff not identifying that their observations and interactions with patients meant they continually assessed patients’ capacity to make informed decisions.

Patient care records did not always evidence staff took account of their responsibilities towards the Mental Capacity Act. Patient care pathways, that nursing staff completed, had a section that patients needed to sign to state they agreed to have their names displayed on the patient journey board. We viewed many examples, where nursing staff had signed the consent and detailed it as a ‘best interest consent’. However, staff did not record how they made the decision that having the patients name displayed was in their best interests or that they had assessed at that time the patient did not have capacity to make that decision. There was no evidence that staff advised patients about what personal details would be displayed. We observed during the inspection, that the depth of personal detail displayed varied across the wards. There was no evidence of involvement of patient's families in the decision.

The trust’s “Bedside Rails for adult Patients Policy” detailed “Bedrails may be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of bed. Bedrails used for this purpose are NOT a form of restraint. Bedrails will not prevent a patient from leaving their bed and falling elsewhere and should not be used for this purpose….. Bedrails used to stop a patient who wanted to get out of bed would be a form of restraint.” Our observations during the inspection showed that most patients had bedside rails raised on their beds. Patient care pathways included a section for nursing staff to assess whether the patient needed bedside rails raised to reduce their risk of the falling out of bed. Our review of patient records showed staff did not always clearly document the reason for the use of bedside rails. For patients whose care records detailed they were confused or lacked understanding of their conditions or situation, there was no evidence that nursing staff had considered whether use of bedside rails was in the patient’s best interests. Contrary to the trusts policy about making best interest decisions, there was no evidence of discussions with the patient or other relevant parties.

During the inspection, we observed one patient on the hyper acute stroke unit (HASU) wearing hand control mittens. Hand control mittens are used to reduce the risk of patients removing tubes and lines that are provided essential treatment. Hand control mittens are recognised as a form of restraint and if not managed correctly can cause harm to a patient’s hand. We reviewed the trust’s policy for the use of hand control mittens, (Clinical guidance for the use of hand control mittens in adult patients, version 1, issued 22 July 2016, review date 21 July 2018). This showed staff did not follow the trust’s policy for the use of hand control mittens. The policy stated, “staff are required to consider the patients capacity to be involved in the decision making process and where at all possible gain the patient’s consent or alternatively the assent of the nominated next of kin” and “patients and their family or carers should be involved in the decision making process.” There was no evidence in the patient’s records that their mental capacity for deciding about the use of the hand control mittens had been considered. There was no record of a best interest decision making process having taken place.
Patient’s medical records evidenced medical staff carried out a brief mental capacity assessment (Admission to Hospital under the Mental Capacity Act 2005 (MCA)) when patients were admitted to hospital. This assessment covered a maximum of the first 48 hours of the patient’s admission to hospital and enabled staff to record they had made a best interest decision that the patient needed to be admitted to hospital. However, the record clearly detailed “Please ensure MCA Best Interest decisions making process is followed and this is discussed with family and relevant others.” As detailed in the records section of the safety domain of this report, medical staff did not always record discussions they had with patients and relatives. This meant there was no assurance that medical staff followed the best interest decision process when patients without capacity were admitted to hospital.

Management of DoLS records did not provide assurance that staff did not deprive patients of their liberty unlawfully. We reviewed records for patients who nursing staff said were subject to a DoLS authorisation. Review of patients DoLS records showed that in many cases urgent authorisations were out of date. There was no confirmation in the patient’s records that a standard authorisation had been granted.

On G1 ward, we reviewed six sets of patient’s notes. For four of these patients, who staff said were subject to Deprivation of Liberty Safeguard authorisation, there was no DoLS application or authorisation in their notes or records.

On G3 ward, we reviewed two sets of patient records. Both records had copies of an urgent DoLS authorisation that had expired. Despite staff on the ward understanding both these patients were still subject to a DoLS authorisation, there was no evidence in the patient’s records that a standard DoLS authorisation had been granted.

On E4, the nurse led complex discharge unit, review of three patients notes showed for all patients that urgent DoLS authorisation had expired and there was no evidence a standard authorisation had been authorised. All three were patients staff understood to be under a DoLS authorisation to prevent them leaving the hospital.

Staff described the process for obtaining emailed authorisation for ongoing standard authorisation when urgent DoLS authorisations expired. This email should be printed and added to the patient notes. This was not happening in practice.

However, we did see some examples that demonstrated some staff had a good working knowledge of the MCA. Staff on D1 ward, a trauma and orthopaedic ward where medical outliers were cared for, demonstrated a good understanding of the mental capacity act and associated deprivation of liberty safeguards. They described an incident where a patient got dressed and left the hospital returning to their home. Once the patient had returned to hospital, the automatic response was to presume the patient needed to be subject to DoLS authorisation to prevent them from leaving the hospital. However, after a mental capacity assessment was completed, the patient was determined as having capacity to understand the reason for their admission and the consequences that leaving the hospital without treatment would have. We saw a well-completed MCA assessment for a patient on the stroke rehabilitation ward (F3). This detailed the decision that needed to be made and the steps that had been taken to help the patient make the decision. For the same patient we saw mental capacity assessments were carried out about the patient’s capacity to consent to insertion of a feeding line. Staff carried out an assessment each time the line was changed and the records showed the patient had fluctuating capacity, which meant that some occasions they consented themselves and on other occasions, the appropriate best interest consent form was completed as they did not have capacity at that time.
Staff on the chemotherapy and oncology wards demonstrated in conversations a good understanding of their responsibilities towards the mental capacity act and associated deprivation of liberty safeguards. One nurse gave an example where they had carried out a mental capacity assessment which had identified a patient had capacity to make decisions when their family was trying to force the patient to relinquish control of their finances and make them a power of attorney. The same nurse described a patient who had an urgent DoLS authorisation because their essential medicines made them confused. However, after a few days, their condition improved and they regained capacity, so the DoLS authorisation was withdrawn.

In the endoscopy service, for many procedures, after completing appropriate training, nurses led the patient consent process. Endoscopy nursing staff, in conversations, demonstrated a good working knowledge of their responsibilities towards the Mental Capacity Act and associated DoLS. This included deferring procedures for best interest decision processes to be completed if they assessed a patient lacked capacity to consent to procedures.
Is the service caring?

**Compassionate care**

Staff cared for patients with compassion

At the last comprehensive inspection of medical services in 2015, we identified some isolated incidents of staff not delivering compassionate care to patients. However, at the inspection of the urgent care pathway in February and May 2017, we found there was a culture of poor care and behaviour which had become normalised for staff with the AMU and across some of the medical services, which resulted in a lack of compassionate care provided to patients. Following our inspection in February and May 2017, we served a Warning notice on the trust that required them to make significant improvements in regard of delivering compassionate care. At this inspection, despite observing some isolated incidents on uncompassionate care, we found most staff delivered caring and attentive care.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 26% which was slightly better than the England average of 25% from December 2016 to November 2017. (Source: NHS England Friends and Family Test)

This showed that for most wards 90% to 100% of patients who responded recommended the ward as a place to receive treatment. Notably F3 ward had made significant improvements. Only 20% of
patients recommended the ward as place to receive treatment in January 2017. In October and November 2017, this figure had increased to 100% of patients recommending the ward as a place to receive treatment.

We observed compassionate and attentive care provided by staff. On AMU we saw staff were observant to the needs of patients and despite being very busy managed to make time to have conversations with patients.

We observed staff treat patients with compassion, kindness and respect. Staff introduced themselves to the patients before they started any care interventions. Most of the time, staff ensured curtains were drawn around patients, on individual room doors were closed to ensure patients dignity maintained.

We observed staff interactions with patients throughout the medical care service showed compassion and care. This included non-clinical staff, such as ancillary and porters as well as clinical staff across all locations. We saw staff spoke with patients in a caring and sensitive manner. Across the medical wards we observed staff provide patients with sensitive support at lunch time. Staff sat next to patients, chatting to the patient, telling them what food there was and giving them time to eat. This was done in an unhurried and sensitive manner.

On C6 ward we observed compassionate and individualised care being delivered to a patient who as having one to one support. The member of staff providing the one to one support engaged the patient in activities. This included including them in completing their own wound care chart and monitoring charts. This reflected the patient’s previous occupation, they had been a nurse.

Staff on the respiratory high care ward demonstrated a commitment to providing holistic care to their patients. They described knowing many of their patients very well, as many had long term respiratory conditions and had frequent admissions to the unit. They described an ethos where a lot of the care that was delivered was about working with the wished of patients who were close to the end of life. They described string links with the community and hospital palliative care team.

We saw an example of compassionate, holistic care on the renal wards, where staff supported a new mother, both emotionally and practically, to bond with her new baby.

We observed medical staff on AMU with a very thorough, good manner with patients.

When talking with staff about patients with mental health needs or autism, staff displayed and understanding and non-judgemental attitudes. However, we found some examples of judgemental and negative attitudes written in the records of patient. Staff routinely referred to all patients in written notes as ‘patient’ rather than as an individual and there were examples of assumptions and negative attitudes towards certain patients. We saw examples of staff ignoring information about patients and making their own judgements. For example, we found information about a patient’s communication skills in a care plan provided by relatives, but staff ignored this and simply recorded that the patient was unable to give a verbal response.

There were numerous positive comments from patients we spoke with. These included, “Nurses are all very friendly and caring”, “I feel safe and well cared for”, “Cleaners, tea people all lovely. care is all good, nurses etc really caring and friendly”, “Care very good, considering how busy’ busy all the time. Respond quickly to call bell”, “Care is wonderful, nothing too much trouble”, “Care is wonderful, nothing too much trouble”, “staff are like a family “calm under pressure” “always with a smile” and for one patient on the chemotherapy and oncology ward “you are the only ones that has made everything about me.”
However, we observed some isolated incidents of uncompassionate care. On D1 ward, we observed a member of staff lean over a patient to write on the white board behind their bed and then take the patient’s records from their bedside and walked away. At no time during this period did the member of staff look at the patient or attempt to communicate verbally or non-verbally with the patient; there was no acknowledgement that the patient was there. One patient on AMU told us they had been upset by one doctor who told them there was nothing wrong with them. They felt their views and feelings were ignored and not considered by the doctor. We heard from three patients on different wards, that staff had failed to support them with their personal needs, which had resulted in the having ‘accidents’. However, all these patients felt it was not due an uncaring nature of staff, but staffing shortages. A patient on one of the wards felt they were being pressurised by medical staff to go home, when they felt their present stage of recovery, meant it was not yet safe for them to be discharged home where they lived on their own.

**Emotional support**

Staff provided emotional support to people to minimise their distress.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about staff delivering emotional support to patients. However, at the inspection of the urgent medical pathway in February and May 2017, we found staff did not always provide emotional support, with patients living with dementia who were upset or agitated not receiving any acknowledgement or reassurance from staff. Following our inspection in February and May 2017, we served a warning notice that required them to make significant improvements in regard of delivering emotional support to patients. At this current inspection we found improvements had been made to the delivery of emotional support to patients.

Throughout our inspection, we witnessed staff supported patients, responded to their needs and mostly communicated with patients in an appropriate way. The service had a broad range of specialist nurses to support patients. These included, heart failure, cardiac rehabilitation, stroke, cancer, oncology, palliative care, diabetic care and respiratory nurses. Nurse specialists give support, advice and information about investigations, treatment and follow up care.

The chemotherapy team held weekly demystifying chemotherapy sessions for patients, their carers and relatives. This was only provided for patients who received intravenous chemotherapy. Information about oral chemotherapy was provided by the chemotherapy nurse specialist. Nurses carried out pre and post first cycle psychological assessments to identify whether patients needed any extra psychological support during their treatments.

The community stroke rehabilitation team considered the emotional and social wellbeing of patients as well as their physical recovery. They linked patients to community support organisations such as stroke clubs. They supported patient with journeys to stroke clubs, reducing and eventually removing that support when patients became confident and safe to travel independently.

Some areas demonstrated commitment to ongoing care and support to relatives in the eventuality of the patient dying. On respiratory high care the ward manager telephoned relatives of ‘well known patients’ following bereavements, to check on their wellbeing and offer support and advice.

Staff supported patients who became distressed in an open environment, and assisted them to maintain their privacy and dignity. Staff worked hard to ensure patients did not become distressed and made use of de-escalation skills.
Observation of care evidenced sensitive conversations between medical staff and relatives in response to a deceased patient.

The trust had a chaplaincy team that included chaplains and volunteers to provide both spiritual and emotional support to patients of different religious beliefs and patients who did not have any religious beliefs. The team provided direct daily support to patients by proactively visiting wards, promoting referrals from staff and ensuring the provision of a 24 hour, 365 days a year on call service for urgent support, primarily at the end of life.

Visiting hours on AMU were flexible, so patients could have support from their relatives in the immediate stages of admission to hospital. Some patients spoke positively about this, saying they felt reassured by having their relative stay with them. Comments included “Visiting very flexible, stay as long as you want, partner stayed all day yesterday” and “wife stayed all night, everyone has been wonderful” and “relative stayed till late last night.” However, other patients commented that the continual coming and going of visitors made the ward noisy and they found it difficult to rest.

On other wards, there were set visiting times. A patient on the stroke rehabilitation ward commented that visiting was restricted to two people at a time between 2pm and 8pm. They said this was not flexible and sometimes caused problems for their relatives visiting. However, conversations with staff indicated that in situations where relatives’ other commitments meant they could not visit at the set times, this would be accommodated to ensure the patient continued to receive the emotional support they needed from their family members.

Five out of six patients we had conversations with on the stroke rehabilitation ward, commented they were bored. One patient said there was “Nothing to occupy me.” Another said they were very bored and spent a lot of the time looking out of the window.

Understanding and involvement of patients and those close to them

Some staff did not consider involving people, carers and their families as an important part of care. People said that staff did not always explain things clearly to them.

At the last comprehensive inspection of medical services in 2015, there were no concerns identified in medical services about staff involving patients and those close to them in decisions about their care and treatment. However, at the inspections of the urgent care pathway in September 2016 and February and May 2017, we found staff did not always support patients and those close to them to be involved in decisions about their care and treatment. At this current inspection we found staff still did not always support patients and those close to them to be involved in decisions about their care and treatment.

Our conversations with patients showed mixed experiences as to whether they were kept well informed about their care and treatment.

Some patients described their experiences of being informed and involved in their care and treatment. A patient on the cardiac day unit said staff drew pictures to explain and demonstrate the narrowing of arteries. The patient said they were fully aware of their treatment plans.

On the stroke rehabilitation ward patients had notes by their bedsides to prompt and remind them about their rehabilitation and discharge plans.

In AMU patients had mixed experiences. All patients in AMU that we spoke with commented that pharmacists discussed their medicine with them and most felt well informed about their care and
treatment plans. We saw nurse specialists supported patients to understand their diagnosis, treatment and discharge plans.

Records from a quality review carried out by the trust prior to our inspection, identified that in AMU there was a lack of communication from healthcare staff to patients about treatment decisions. We found some patients described experiences where staff had not kept them informed about their treatment plans. One relative told us staff did not keep them updated about their family member’s care and treatment, they had to ask for updates. Discussion with a patient on AMU indicated there were delays in informing them about their treatment plan. An investigatory procedure had been planned and then cancelled, but there was a significant delay in a member of staff explaining to the patient or their relatives why the procedure had been cancelled and their ongoing treatment plan.

Patients on C6 described a similar mixed picture. Although most patients said a pharmacist had discussed their medicines with them, one patient told us “I wasn’t given a full explanation of medicines, I had to ask what they are for.” Although most patients said doctors and nurses gave them regular updates, one patient told us they had undergone lots of tests, they were “not really sure” about their ongoing treatment and felt communication about what was happening was poor, they had to ask for updates.

Our review of medical records, showed medical staff rarely documented any discussion they had with patients and relatives about their treatment plans.

Our observation of care at the Amurulee day unit at St Marys Hospital, showed staff did not always involve patients in discussions about their care and treatment. We observed one member of staff explained to the CQC inspector what assessments they were carrying out on the patient but they did not explain this to the patient who was present in the room.

Is the service responsive?

Service delivery to meet the needs of local people

The service did not plan and provide services to fully meet the needs of the local population.

At the last comprehensive inspection of medical services in 2015 and the inspection of the urgent medical pathway in September 2016 and February and May 2017, we found patients were not consistently cared for in same sex accommodation areas. In February and May 2017, we found that although staff reported mixed sex breaches, the trust declared some of these as medically required and so did not deem them as mixed sex breaches. Following the inspection in February and May 2017 the trust was required to report all mixed sex breaches as they occurred in line with the Department of Health guidance.

Prior to the inspection the trust declared that the cardiac day unit and E6/7 wards still did not meet the single sex accommodation guidance. On the cardiac day unit, toileting and bathing facilities meant single sex accommodation was not provided. To minimise the effect this had on patients, the unit used screening to separate male from female patients, however this did not address the lack of single sex toileting and bathing facilities. Staff did not consider mixed sex breaches for day case patients, only those that were admitted overnight as outlier patients. Staff gave all patients they identified as experiencing a mixed sex breach a letter of apology.

On E4, the nurse led complex discharge unit, the female toilet was situated next to the male toilet and shower which meant female patients had to walk past the male toilet to reach the female toilet. Furthermore, the female toilet was signed as a male toilet, which meant it could not be assured that male and female patients did not use the same toilet facility. The female showering
facility in E4 was shared with the surgical high care unit and necessitated some female patients having to walk past the male sleeping accommodation to reach the female shower facilities.

Staff did not use a system to enable them to quickly identify patients who had dementia or who may have a memory problem. The trust told us they had reintroduced the Forget-me-not scheme to help staff identify and support patients with dementia or impaired memory. Part of this scheme is that patients who have dementia or impaired memory have a forget-me-not flower displayed by their bedside. However, despite most wards having notice boards that displayed information about this scheme there was inconsistency in the use of it. During the inspection we did not see any forget-me-not flowers used by patients’ bed sides to act as visual prompts.

The trust had a learning disability nursing team who worked across the hospital to support patients with a learning disability. They provided assessment, advice and support to staff, patients and carers. We saw evidence of frequent contact between the learning disability liaison team, patients and ward staff.

The community services stroke rehabilitation team, which was part of the medical clinical service centre (CSC), had developed their service to meet the needs of the local population. This included the decision not to split the area geographically, and to work in multidisciplinary teams so the service was flexible to meet the individual physical, rehabilitation and emotional needs of patients.

The trust identified many patients who had delayed discharges due to a lack of coordination in discharge planning to meet their complex needs. To address this, an unfunded nurse led complex discharge unit (E4 ward) was set up to facilitate complex discharges. An integrated discharge service supported discharge planning for patient with complex needs. However, we were not provided any data to show the complex discharge unit was supporting improvements with timely discharge for patients.

As part of the winter pressure planning the trust had taken steps to ensure patients were treated and cared for safely. The trust identified areas of the hospital that could be used as escalation areas when the hospital ran out of funded beds for inpatients. The trusts Capacity Management policy that included escalation measures (October 2017) set out the actions staff needed to take and areas of the hospital that the service could use as escalation areas in the event of capacity issues. However, review of this policy and the associated action cards identified escalation areas no longer used, such as the discharge lounge, were still included in the policy.

The new medical model of working, meant there was a physician of the day at the front door who worked in the emergency department (ED) and the acute medical unit (AMU) This supported the management of the increasing number of patients with comorbidities who presented at the hospital.

**Meeting people’s individual needs**

There were shortfalls in how the needs and preferences of different patients were taken into account.

At the last comprehensive inspection of medical services in 2015, we identified staff did not always use available tools to support the provision of care to patients living with dementia. At our inspections of the urgent medical pathway in September 2016 and February and May 2017 we found staff did not always consider the needs of people living with dementia and at this current inspection the situation remained unchanged..

The National Audit of Dementia Care in General Hospitals 2016 – 2017 carried out by the Royal College of Psychiatrists and published in July 2017 identified the trust as one of the poorest
performing trusts for care of patients with dementia. The trust had one of the worst performances for carer rating of information and communication and carer rating of patient care. The trusts action plan following the publication of this audit detailed they were “Relaunching the ‘This is Me’ document and ensuring that this is embedded in practice with an audit planned for January 2018.” The ‘This is Me’ document is a simple document for anyone who receives professional care who has dementia or experiences delirium or other communication difficulties. It provides an easy and practical way of recording who the person is and supports the delivery of person centred care.

For patients living with a learning disability, it is common practice for them to have a ‘Hospital Passport’. This is a document held by the patient and completed by their care staff that is designed to give hospital staff helpful information such as lists of what the person likes or dislikes, from the amount of physical contact to their favourite type of drink, as well as their interests. Out of the 48 patient records we reviewed we found only four ‘hospital passports’ or ‘this is me’ booklets. However, staff did not always use these to inform the hospital care plans. We found an example of a ‘hospital passport’ that stated a patient required supervision when eating due to epilepsy and risk of choking, but the hospital care plan for diet and nutrition stated that the patient required a fork mash-able diet and red tray but did not specify that supervision while eating was required.

Staff completed training about the Mental Health Act, but staff felt the training was limited and did not provide them with the appropriate skills to care for patients with mental health needs. Many staff reported relying on carers and families for advice and information on how to best care for patients with a mental health or learning disability diagnosis.

The environment of wards where patients with dementia were cared for were not dementia friendly. In most wards there was no easy to identify prompts for patients to identify their bed areas and bathing and toileting facilities.

Staff spoke about activities they could facilitate for patients with dementia. Wards had activity trolleys that provided a range of activities staff could support patients to engage in. However, we did not see use of any of these activities during our inspection of the service. A Memory Lane facility on one of wards was available to facilitate group social activities for patients living with dementia. We reviewed the Memory Lane calendar for April 2018. Activities included Pompey Pals, Folk active, knitting, hair and beauty, little people’s nursery. Dedicated staff coordinated the activities. However, it was the responsibility of individual wards to identify patients suitable to attend the activities and to support patients to attend. Staff explained, that although this facility was available, current staffing levels meant it was almost impossible to support any patients to attend the activities.

Review of patients’ nursing care plans showed there was scant information about how to support patients to meet their individual needs. For example, a patient on C6 ward who had dementia, their assessment for communication detailed they had dementia and the plan of care was to ‘ensure glasses are on, inform patient about the plan and reassure’ There was no specific detail to best to communicate with the patient. On F2 ward, for one patient their communication assessment detailed they were slightly hard of hearing, English was their first language and they were slightly confused. Their associated communication care plan detailed that to meet the patient’s communication needs, staff had to “monitor, encourage to raise concerns and find time to talk to the patient.” There was no detail about how to best communicate with the patients.

On C7 ward, for a patient with diabetes, their care plan gave no guidance about the type of diet they needed to eat, how frequently staff had to monitor and record the patients’ blood sugar levels, what range the blood sugars should be and what actions staff needed to take if the patients’ blood sugars were outside the safe range. On E7 ward, for a patient who had a learning disability,
dementia and was also blind and partially deaf, their care plan did not give detail about any actions staff needed to take to meet this patient’s specific individual needs.

We found that for patients across all wards who were assessed as requiring assistance to eat and drink, their records did not detail about the type of assistance the patients needed. This meant staff did not know have guidance as to whether patients needed food cut up, or whether they needed full assistance i.e. feeding.

For a patient on AMU whose assessment and care plan detailed they had difficulties swallowing and could only eat soft diet and small pieces of food. They were prescribed and dispensed antibiotics that were too big for them to swallow.

Staff had access to translation services, for patients whose first language was not English. However, information leaflets were not readily available in languages other than English.

In conversations, staff displayed an understanding and non-judgemental attitude towards caring for patients with mental health needs or autism. We saw examples of staff ignoring information about patients and making their own judgements. For example, we found information about a patient’s communication skills in a care plan provided by carers/relatives but the hospital care plan ignored this and simply recorded that the patient was unable to give a verbal response.

The service relied on local mental health crisis teams and the Approved Mental Health Professionals assessment service out of hours for urgent and emergency mental healthcare needs. These services provided telephone support to staff but could not provide practical support.

**Access and flow**

Processes to support patient flow through and out of medical services were not yet fully embedded into the running of the service.

At the last comprehensive inspection of medical services in 2015, we identified some patients (including patients living with dementia), experienced multiple bed moves during their admission to hospital and there was a lack of processes to safely mange patients care on wards other than their specialty wards (outliers). Inspections of the urgent medical pathway in 2016 and 2017 identified there was poor patient flow throughout the hospital which impacted on staff ability to deliver safe patient care. At that time, the AMU had an occupancy rate of 105%, use of escalation beds was widespread across the hospital and patients frequently experienced bed moves for non-clinical reasons. Following our inspections in February and May 2017 the trust was served a warning notice that required them to make significant improvements to patient flow throughout the hospital.

Since that inspection the trust has been supported by NHSI and the local CCGs to identify areas for improvement and make those improvements. One of the trusts associate medical directors was the lead clinician for unscheduled care which supported effective patient flow throughout the hospital. They championed more effective ways to improve patient flow. This included the implementation and embedding of the Red2Green initiative which is part of the NHS Safer Care bundle. This is a visual management system to assist identification of wasted time in a patient’s journey. It is used to reduce internal and external delays as part of the SAFER Care bundle. A red day is when a patient receives little or no value adding acute care. A green day is when a patient receives value adding acute care that progresses their progress towards discharge. It was noted that at the time of our inspection of the services, patient flow had improved and there which had meant, for the first time in several months, there were no escalation beds open. However, there were still medical outliers, accommodated in surgical wards.
Average length of stay

Queen Alexandra Hospital

From December 2016 to November 2017 the average length of stay for medical elective patients at Queen Alexandra Hospital was 4.4 days, which was lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 8.9 days, which was higher than England average of 6.5 days.

Elective Average Length of Stay - Queen Alexandra Hospital

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology, gastroenterology and nephrology was lower than the England averages.

Non-Elective Average Length of Stay - Queen Alexandra Hospital

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was higher than the England average.
- Average length of stay for non-elective patients in cardiology and nephrology was similar to the England averages.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From January to December 2017 referral rates for admitted pathways have been worse than the England averages. The trust performed most poorly in October 2017 when referral to treatment rates at the trust showed that 59.3% of patients were treated within 18 weeks compared to the England average of 89.0%. In the most recent month of data, December 2017, referral to treatment rates at the trust showed that 77.5% of patients were treated within 18 weeks compared to the England average of 88.3%
Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>95.6%</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

Six specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>87.5%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>78.4%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>76.5%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>63.2%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>50%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

As part of the trust registration conditions, they were required to submit data to CQC about the use of escalation beds. The data for February 2017 to February 2018 showed a gradual decrease in the number of escalation beds in use. In February 2017 there had been between 55 to 86 escalation beds in use each day. In February 2018, this figure was 34 and at the time of the inspection, there were no escalation beds in use.

However, during the same time, the number of medical outliers had slightly increased from 1105 to 1212 per month. For the same time, the number of overnight bed moves for each month had slightly reduced from 1552 to 1383. However, these figures did not differentiate between clinically needed bed moves and no clinically needed bed moves.

Following the inspection, the trust sent updated data regarding patient flow through the hospital. The data covered the period Monday 16 April to Sunday 29 April 2018. This showed for that period, there had been eight days when the trust had no escalation beds opened and the maximum of escalation beds opened at any one time was four. During those dates, the number of medical fit patients waiting for discharge reduced from 226 to 171. However, reducing figures were not replicated in the number of medically fit for discharge bed days lost (1796 to 1918) or the number of patients who had delayed transfers of care (131 to 151).

The trust provided data about the Red2Green initiative. This showed for the same time increasing numbers of patients who had no recorded Red2Green situation on the trusts electronic bed view system. This meant the service could not identify whether the patients had a time-wasted day with
no care or treatment that actively progressed their treatment. Conversations with staff on wards indicated they were aware of the Red2Green initiative, but they could not describe how it was improving patient flow through the hospital. Staff did not describe any actions they were taking to increase the number of green days patients experienced. Review of Quality and Governance meeting records for the clinical business centres, showed the Red2Green days data was not reviewed. This meant there was no formal process for staff to identify where they could use this tool to identify actions that they could take to improve patient flow through the hospital and reduce patient’s length of stay.

Staff spoke about the impact poor patient flow and the use of escalation areas had had on patient experiences. For example, on the oncology ward there was a four-bedded area used to directly admit patents for assessments. However, at times of bed pressures this area was used as an outlier area for medical patients. This meant oncology patients whose immune systems were compromised due to ongoing treatment, were placed at risk of cross infection having to be assessed in the emergency department. Staff described that in November and December 2017 and January 2018, it was not unusual for this room to be full of medical patients five out of seven days a week.

Staff on both the hyper acute stroke unit, cardiac high care and respiratory high care spoke about the challenge of having a vacant bed available for patients who required time critical treatment. However, staff did not describe any incidents where patients had to come to harm due to lack of bed availability to provide time critical treatment.

The trust used the NHS Safer Care bundle to improve patient flow through the hospital. This recommends that of patients ready for discharge, trusts should discharge 33% of them by midday. The trust monitored the percentage of patients ready for discharge who were discharged by 1pm. The trust provided data for the period 19 March to 38 April 2018. This showed that overall, the trust failed to meet the target that 33% of patients should be discharged before 1pm. The trust also failed to meet their target that 70% of patients should be discharged before 4pm. The trust did not provide any historical data regarding patients discharge times, so we could not assess whether failure to meet the recommended target for time of discharge was an ongoing problem. However, conversations with staff indicated this was an ongoing concern.

The trust had a discharge lounge, which supported patient discharges and allowed beds on the wards to be made available for patient admissions. To support patient flow, the trust introduced the practice of identifying ‘early birds’. Ward staff identified one or two patients who were planned for discharge the following day who were safe to wait in the discharge lounge from its opening on the day of discharge. However, this process was described as being frequently ‘abused’ by ward staff. Prior to the opening time of the discharge lounge, it was reported that staff were frequently waiting with patients who had not had a morning wash and were not dressed in outside clothes. This did not meet the standard operating procedures for the discharge lounge and did not promote the dignity of patients, as there were no private washing facilities available in the discharge lounge for their use. These occurrences were not reported as incidents, nor detailed on the medicine clinical services centre risk register.

As well as the Red2Green initiative, the service had taken other actions to support improved patient flow through the hospital. Medical staff said the ‘new medical model’ of working was resulting in most patients being assessed by an appropriate consultant and thus commencing their treatment plan in a timelier manner. Often the patient was assessed by the appropriate consultant in the emergency department, where as previously patients may have waited until they were
admitted from AMU to the relevant specialty ward to commence their treatment plans. However, the service did not provide any data to support this view.

The cardiology service ran rapid access cardiology clinics and fast access chest pain clinics with the aim of reducing hospital admissions. Audit of the rapid access cardiology clinic carried out between June 2104 and January 2015 showed that 27 overnight patient admissions were avoided. The trust did not provide any recent audit results for this service. Audit of the effectiveness of the fast access chest pain clinics for November 2016 to July 2017 showed that there were no cardiac admissions for all 150 patients whose data was used for the audit purposes.

In response to complex medically fit patients reducing the bed availability of the hospital, an 18-bedded unfunded nurse led complex discharge unit had been set up by the trust two and a half years ago. There were no plans to get this unit recognised and appropriately funded. It had initially been set up as a short term, temporary solution to improving discharges and patient flow, but had now been open for over two years. The unscheduled care clinical lead said the plan was to improve patient flow through the hospital with the use of the NHS Safer Care bundle and the Red2Green initiative in order to achieve closure of this temporary unit. There was no timescale set yet for achieving this result.

The trust had a Capacity Management Policy (including escalation measures) dated October 2017, review date 30 April 2020. This provided staff clear guidance about the actions that staff needed to take when there was reduced availability of beds for patients. This included clear descriptions of the different stages of escalation (green, amber, red and black or Opel 1, 2, 3 and 4) and capacity issues. The policy detailed a list of triggers, such as more than six unplaced patients waiting for a bed at 8.30am, funded capacity and some escalation areas open and AMU have more than three patients waiting to be moved. If four or more of these triggers were met, the trust activated the full capacity policy. Activation of this policy was independent of the level of escalation the hospital was at.

Patient access to cardiology treatments had been adversely affected by the CDU having to take outlying patients both during the day and night. The cardiology service had a comprehensive action plan they were following to reduce and clear the backlog of procedures. The plan indicated that the backlog of urgent procedures would be cleared by 2 April 2018. We did not have any confirmation this had been achieved.

The trust operated a multiagency integrated discharge (IDS) from the hospital site, the IDS was made up of multidisciplinary staff from neighbouring local authorities, community NHS trusts and staff directly employed by the trust. Staff on the wards spoke positively about the support the IDS team provided in delivering coordinated discharge plans for patients with complex health and social needs.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them, but there was lack of process to ensure learning from complaints was communicated and shared across all staff groups.

At the last comprehensive inspection of medical services in 2015, we identified no concerns about the management and learning from complaints and concerns. Prior to our inspections of the urgent medical pathway in September 2016 and February and May 2017, we received information from patients and stakeholders which indicted the service did not always respond to patients’ complaints in a satisfactory or timely manner. Prior to this inspection, we continued to receive
information from patients and stakeholders which indicted the service did not always respond to patients’ complaints in a satisfactory or timely manner.

Summary of complaints
From January to December 2017 there were 240 complaints about medical care which was the highest volume of complaints for any core service at the trust. The trust took an average of 47 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be completed within 30 working days. Complaints were most commonly related to clinical treatment or admission, discharge or transfer.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
We reviewed the complaints log for the Clinical Service Centres (CSCs) that delivered medical services. This showed the main themes of complaints received both directly to the service and form the PALS service, were regarding delays in treatment, lack of communication from healthcare staff (both nursing and medical) and concerns about care and treatment. Only the renal and transplant CSC and the medicine for older people and rehabilitation services (MOPRS) CSC complaints log detailed any actions or learning identified following investigation of the complaint. AMU monitored themes and included themes of complaints in their monthly newsletters to staff.

Staff said complaints and learning from complaints were discussed at handovers and safety huddles. However, it was not evident that CSCs had oversight of complaints received about their services. Records showed themes and learning from complaints were not reviewed at the CSC’s governance and quality meetings.

The trust provided examples of practices that had changed because of patients raising concerns or making a complaint. AMU provided patients with eye masks and ear plugs to reduce the level of noise and light patients experienced at night. Patients on the respiratory day ward complained about the length of time they waited on the unit for their procedures. In response the ward had changes their practices, reducing the length of time patients had to wait. Respiratory high care developed a patient information leaflet about non-invasive ventilation in response to patients and relatives ongoing queries about this. The respiratory service used patients experience stories as described in complaints, to support the ongoing training and development of staff.

Detail about how to raise a concern or complaint was available on the trust’s website and in information leaflets available on the wards.
Is the service well-led?

Leadership

Managers across medical services had the skills, ability and commitment to run a service that was focused on improving patient experiences.

At the last comprehensive inspection of medical services in 2015, we identified no concerns about the leadership of medical services. However, at our inspections of the urgent medical pathway since February 2016 we found the quality of leadership across the medical services was variable. Following our inspection of the urgent medical pathway in February and May 2017, we service a warning notice that required them to make significant improvements with the leadership of services.

At this current inspection, we found leadership of the medical services was an improved picture.

The trust operated 11 Clinical Service Centres (CSC) who led services. Each CSC had a chief of service, head of nursing, clinical directors, general manager, operational manager, and a governance and quality lead plus a team of matrons. There were governance leads covering all CSCs, some of which covered more than one CSC. Medical services were led by four different CSCs. General medical wards, including respiratory, cardiology, short stay, gastroenterology and a step down ward were led by the medical CSC. Stroke ward, rehabilitation ward and elderly care wards were led by the Medicine for Older People and Rehabilitation Services (MOPRS) CSC. The renal medical wards were led by the Renal and Transplant CSC. AMU was part of the Urgent Care CSC, which also included the emergency department. Staff told us that all the local management team were visible, accessible and provided good help and support.

However, the trust was in the process of restructuring services across the trust into four divisions, which meant the leadership of medical services would be changing. Staff were aware of this, but remained committed to working in their present CSCs to bring about changes and improvements to the services prior to the new leadership structure being put in place.

We found leadership teams were well informed and had a cohesive understanding of the challenges facing their services and what needed to be done to improve the services.

The trust had appointed one of the trust’s associate medical directors as the clinical lead of unscheduled care, who was championing more effective ways to improve patient flow through the hospital

There was shared leadership between the lead medical clinician and matron for AMU. This was an improvement from February and May 2017, when nursing staff had a limited voice into the running of the unit and there had been a poor working relationship between medical and nursing staff. Joint meetings were now held between medical staff and senior nursing staff. The clinical lead of AMU said that nursing staff now instigated changes and improvements to the service, this had not happened previously.

Vision and strategy

Medical services did not have an established vision and strategy for the development of their services.

At the last comprehensive inspection of medical services in 2015, we found medical services did not have a long-term strategy for the services. At our inspections of the urgent medical care pathway since 2016 we found, that although there was a strategy to improve the urgent medical pathway, the strategy was failing to bring about the required improvements.
At this current inspection we found the trust was in the process of developing a new vision and strategy for what it wanted to achieve together with workable plans to turn it into action. This was being developed with involvement from staff we spoke with.

Individual CSCs, did not have their own vision or strategy, other than being part of the programme to improve patient flow though the hospital using the new medical model of working and the tools championed by the unscheduled care clinical lead. They were waiting for the development of the trust strategy and the proposed reconfiguration of CSCs, before working with their staff to develop their own vision and strategy.

We saw most wards displayed the trusts values of working together, quality of care, efficiency and privacy and dignity in reception areas to their wards. E6/7 ward was the only ward where we found their own developed vision was displayed.

Culture
There was an improving culture in the medical services, but there were still examples of some clinicians not working cohesively.

At the last comprehensive inspection of medical services in 2015, we found there was limited integrated working between different clinical service centres, such as between medicine, emergency medicine and surgery. At our inspections of the urgent medical care pathway since 2016 we found staff were demoralised, feeling they were not listened to by senior leaders. There was a culture of some medical consultants not engaging with changes made to the delivery of services. At this current inspection, staff reported an improving culture, which staff believed was led by the positive and respectful behaviours of new CEO and executive board. Staff felt, with the new executive board, positive changes to services would now happen.

Staff across all areas described a culture of team working, supporting each other in their work. However, comments received by a member of the AMU staff suggested that for some staff there was insufficient acknowledgement and support provided in relation to the emotional impact of providing high standards of care with a reduced workforce.

Some wards demonstrated innovative ways to promote a positive culture on their wards. For example, on C6 ward, the ward manager had introduced a ‘Shout Out’ board, for recording positive messages. Staff were encouraged to write work related complimentary messages about staff on ‘post it’ notes and attach them to the ‘shout out’ board.

Staff said that where as previously there had been a pervading blame culture, where if something went wrong, someone needed to take the blame for it, there was now a ‘no blame’ culture. The ‘no blame’ culture was supporting effective reflection of practices and ongoing improvements to the services. They told us they could report concerns to their managers without fear of retribution. Staff knew how to contact the trust’s “Freedom to Speak up Guardian”.

We asked staff about the Duty of Candour. Most staff were familiar with it and told us what it meant in practice. Some staff provided examples where they had followed the Duty of Candour process. We saw records, which evidenced staff followed Duty of Candour processes.

However, staff reported there were still some pockets of staff behaviours that did not demonstrate a positive and supportive culture. Despite the improvements made in the culture of AMU, some medical staff reported that at times there was still some separated working between nursing and medical staff. On C6, nursing staff reported, they had to spend time reviewing medical notes to determine what changes had occurred at ward rounds, because consultants carried out ward rounds without involving the nursing staff and did not verbally hand over any changes in treatment.
plans. Staff on one ward commented their ward manager did not listen to their concerns, rarely interacted with staff and some staff felt the manager displayed some bullying behaviours. Staff commented that several members of staff had left employment due to the behaviours of the manager.

**Governance**

Medical services’ governance processes did not provide an effective systematic approach to identify areas for improvements and thus support improvements to the services.

At the last comprehensive inspection of medical services in 2015, we did not find any significant concerns with the governance of medical services. At our inspections of the urgent medical care pathway since 2016, we found governance processes were not effective at ensuring the quality and safety of care delivered to patients. At this current inspection we found, that governance processes were still not fully effective.

For each CSC, there was a lead consultant for governance and the head of nursing led on quality and safety for all governance matter. They were supported by a governance coordinator and governance administrator. Each CSC held monthly governance and quality meetings, although at times of operational pressures these meetings did not take place. There were standing items on the agenda each month and, in addition, there was a different focus each month. Standard agenda items included review of action logs from previous meetings, review of serious incidents, review of the CSC’s Quality Improvement Plan (QIP), ratification of policies and guidelines and review of governance reports from speciality services within the CSC.

Review of quality and governance meetings referred to a trust wide quality review that was carried out on 16 March 2018. Review of the findings of the trust wide quality review, showed concerns with staff understanding and application of the mental capacity act and associated deprivation liberty safeguards, security of patient records, security of storage of medicines, out of date medicines, quality of dementia care, poor completion of patient records, lack of communication to patients and relatives about treatment decisions, cleaning chemicals not stored securely, care plans and assessments not completed and not individualised, call bells not answered in a timely manner and on some areas no awareness of the ‘This is me’ or hospital passport documents. It was not evident these concerns had been identified by the individual CSCs prior to the trust wide quality review. It was concerning, that despite these issues being identified prior to our inspection, any action take had not resulted in improvement, as these were all concerns we identified during our inspection process. However, the trust wide quality review did not identify all the concerns we identified, such as poor management of medicine fridge’s.

There was good managerial oversight of incidents. The senior management team of each CSC was supported by a governance coordinator and an administrator, who maintained a database of incidents, arranged for these to be reviewed by the management team and monitored the progress of investigations. There were weekly panels to review incidents which were graded ‘moderate harm’ or above. However, review of incidents reported to the NHS national reporting and learning system, (NRLS) raised concerns that not all incidents were reported. Despite nursing staff saying staff shortages posed a risk to safe patient care, there were no incident reports of staff shortages.

It was not evident through discussions with staff and leaders, or from review of governance and quality meetings, that the service leaders had good oversight of or shared learning from complaints.
We were told about weekly observation sessions that were due to commence in the month following our inspection. These were to be undertaken by a clinical and a non-clinical staff member to assess patients’ experiences. They were known as ‘Sit and see’ and focussed on patients being treated with dignity and respect. The results of these observations would be fed back into the monthly governance and quality meetings.

**Management of risk, issues and performance**

The trust did not have consistently effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

At the last comprehensive inspection of medical services in 2015 and our inspections of the urgent medical pathway since 2016 we found risk management processes were not effective at identifying and managing risks to the service.

The individual CSCs maintained a risk register which recorded known risks and rated them according to their potential impact. As part of our assessment of how medical services managed risks, we requested that the trust provide us with the individual CSC’s risk registers. Review of the risk registers showed they reflected what staff had told us was on their ‘worry lists’. However, some risks identified by us during the inspection were not included on all CSC’s risk registers. The risk to patients’ liberty due to staff not having a good understanding of the Mental Capacity Act and associated Deprivation of Liberty Safeguards was only detailed on the MOPRS and the AMU risk registers. The risk to patients not receiving appropriate care and treatment due to incomplete patient assessments and lack of individualised care plans was not detailed on any of the risk registers.

Most risks on the registers had an identified lead manager and a review date, but there was no detail recorded of any actions completed or planned to mitigate the risks. We saw that the risk register was regularly reviewed at governance and quality meetings, but most records of these meetings did not detail actions to mitigate the risks. Following review of the draft evidence appendix, the trust told us that records of actions taken to mitigate risks were included in their electronic incident recording system. However, they did not provide any additional evidence to support their statement.

The trust was in the process of developing its systems for identifying risks. The trust told us enhanced training in risk management would be delivered during 2018 to ensure that all parts of the organisation had a better understanding of the importance of effective risk management.

Monitoring of performance occurred at the monthly quality and governance meetings. The Stroke unit monitored their performance with the use of the national SSNAP audit and acted to improve the service. The endoscopy unit carried out regular audits to measure their performance and identify areas for improvement.

**Information management**

The trust collected, analysed and used information to support all its activities, but there was lack of assurance that the information systems supported effective sharing of patient information.

Information Governance Issues and Compliance Framework was a standard agenda item on the CSC’s governance and quality meetings.

Staff were familiar in the use of computers for training, HR, and appraisals and aware of the data security requirements.
Medical staff spoke positively about the electronic patient record system which supported effective work flow. The system allowed handover lists to be made, linked in to laboratory results and X-ray results and tracked patients that needed a review, so medical staff could identify the patient’s location in the hospital.

However, different electronic systems were used during the night and day shifts. At night requests for medical review were made through an electronic system that was monitored and coordinated by the night matrons. There was no process to give assurance that patients who had not been reviewed by the night team, were reviewed by the day team. The work was handed over verbally between the night and day teams, but the two electronic systems did not interface. The hospital at night team, deleted previous night’s requests that had not been actioned on the night electronic system at the beginning of the next night shift without seeking assurance that the patient had been reviewed by a clinician.

A similar concern was identified for patients who had a mental health diagnosis. Sharing of information between trust staff and local mental health teams to support effective care for patients was compromised because the mental health services were provided by three separate NHS mental health trusts. Each used a different electronic record system and the trust used either paper records or a fourth electronic recording system.

**Engagement**

There was a limited approach to sharing and obtaining the views of people who used the service. However, there was improved engagement with staff across medical services and the trust.

At the last comprehensive inspection of medical services in 2015, we did not find any significant concerns with how the service and the trust engaged with staff and people who used the service. However, in our inspections of the urgent medical pathway since 2016 we found a lack of engagement with both staff and people who used the service. At this current inspection we found some improvements in engagement with staff, but limited engagement with people who use services.

Previous inspections identified poor staff engagement. At those inspections staff felt the previous executive board did not listen to their concerns about the challenges in improving good quality care. They felt the executive board did not consult with staff about any required changes, staff were just told what they had to do. This resulted in poor ‘buy in’ from some staff groups in making the required changes and improvements to services and staff felt ‘change fatigued.’

At this current inspection staff side engagement was improving across the trust. Staff felt the new executive team was listening to and acting on their views and concerns. For example, the chief executive officer (CEO) had visited the discharge lounge where the manager showed him around the environment and alerted him to the fact there were no toilet or washing facilities, patients had to go to one of the nearby wards or use the staff toilet. The CEO had responded in a manner that gave the discharge lounge manager confidence that toilet and washing facilities would be provided soon.

The CEO communicated with staff through regular emails, weekly messages posted on the trust’s intranet and internet, visits to wards and holding drop in sessions. However, staff commented it was difficult to attend the drop-in sessions due to staff shortages and work pressures.

Nursing staff said their matrons and heads of nursing were all on the side of staff and patients. They listened to staff views and when possible acted on the views of staff.
Wards and units use differing ways to disseminate information to staff. Some wards produced weekly or monthly newsletters. These included lessons learnt from incidents and complaints, any special events happening on the wards and any complements the ward or unit received. On the oncology and chemotherapy wards they had a ‘Super 7’ notice the rear door of staff toilet. This detailed the top seven reminders and important notices that staff needed to be aware of. The notice was changed every week to ensue staff were aware of current information.

The CSC leadership teams described an improvement engagement from consultant medical staff with the medical model and urgent care pathway practices. However, there were still pockets of resistance and lack of engagement from some consultant medical staff.

The clinical lead for the urgent care pathway, said that some teams, (nursing and medical), were not yet fully engaged with the Red2Green process and safer care bundle. Staff said they could not see any improved outcomes from the use of the processes, which resulted in a lack of engagement from them. During our inspection of the wards, staff did not tell us about the Red2Green process or the Safer care bundle when we asked them about patient flow and patient discharge challenges. This indicated staff were not fully engaged with the processes. The clinical lead for unscheduled care was using peer reviews to improve engagement of staff. He was also using those teams that were fully engaged with the process to enthuse the teams that were not.

Medical services used the friends and family test to capture patients’ feedback. Results of this were reviewed at governance and quality meetings. Medical services did not provide any information about any patient forums that would support engagement and involvement of the local community.

**Learning, continuous improvement and innovation**

The trust, medical services and individual staff members were making changes to support innovation and sustainability of the services.

The trust had appointed a clinical lead for the urgent care pathway who was leading changes and improvements to improve patient flow through the hospital. This included engaging with members of enthusiastic staff to lead quality improvement projects.

A junior doctor on the oncology and chemotherapy ward who demonstrated enthusiasm for improving services was tasked to improve compliance of medical staff completing VTE assessments. In October 2017 the compliance rate was 0%. At the time of the inspection, because of this doctor’s work, the compliance rate had improved to 83%.

The respiratory high care unit was planning to develop a ‘flying squad’. This would be a team to support and manage outlying patients on non-invasive ventilation.
Surgery

Facts and data about this service

Portsmouth Hospitals NHS Trust provides district general hospital surgical services at the Queen Alexandra Hospital. The surgical specialties offered at the hospital are urology, breast and plastics, lower and upper gastrointestinal, vascular surgery, bariatric and general surgery.

The trust is an orthopaedic centre, providing elective and emergency trauma surgery, with the head and neck clinical service centre (CSC) at the trust also providing ophthalmic surgery, dental, maxillo-facial and oral surgery. Dermatology services which require minor surgical procedures are provided off site at St Mary’s Hospital.

(Source: Routine Provider Information Return (RPIR) – Sites-Acute tab, trust website)

The trust had 48,377 surgical admissions between December 2016 and November 2017. Emergency admissions accounted 13,126 (27%), 28,630 (59%) were day case, and the remaining 6,621 (14%) were elective.

(Source: Hospital Episode Statistics)

We inspected elements of two clinical service centres (CSC): surgical services from the surgery and cancer CSC; and theatres from the CHAT (Critical Care, HSDU, Department of Anaesthesia and Theatre) CSC.

Is the service safe?

Mandatory training

Mandatory Training completion rates

The service provided mandatory training in key skills and staff received effective training in safety systems, processes and practices, however completion rates in surgery were much better for nursing staff than for medical staff.

The trust set a target of 85% for completion of all mandatory training modules, aside from information governance which was set a target of 95%.

In surgery medical and dental staff failed to meet the target with 79% compliance overall, but qualified nursing staff met the target with 91% compliance overall. A breakdown of compliance for mandatory courses for medical and dental staff from April 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>332</td>
<td>342</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>331</td>
<td>342</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>327</td>
<td>342</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>319</td>
<td>342</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>318</td>
<td>342</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>62</td>
<td>72</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>293</td>
<td>342</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>259</td>
<td>305</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>286</td>
<td>342</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff met the target in seven of the 18 training modules. Staff failed to meet the target in all other modules, including adult basic life support where 213 of 318 eligible staff had completed the training.

A breakdown of compliance for mandatory courses for qualified nursing staff from April 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Reporting</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 3 years</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>545</td>
<td>554</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>545</td>
<td>554</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>517</td>
<td>526</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>498</td>
<td>510</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>522</td>
<td>554</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>456</td>
<td>522</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>392</td>
<td>467</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>442</td>
<td>529</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>328</td>
<td>397</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Specialty Specific Fire Safety</td>
<td>110</td>
<td>150</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>227</td>
<td>523</td>
<td>43%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Acute Pain Management (Registered Staff)</td>
<td>77</td>
<td>206</td>
<td>37%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>7,984</td>
<td>8,817</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Qualified nursing staff met the target in 13 of the 19 training modules, achieving 100% compliance in seven modules. Staff failed to meet the target in six modules with acute pain management the module with the lowest compliance where 77 of the 206 eligible staff had completed the training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

**Safeguarding training completion rates**

Staff understood how to protect patients from abuse and staff had training on how to recognise and report abuse and they knew how to apply it. There were arrangements to safeguard adults and children from abuse and neglect that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures, including working in partnership with other agencies.

Staff we spoke with understood how to report safeguarding concerns and they were able to discuss escalation procedures relevant to their position. Safeguarding information was available on the surgery wards. There were safeguarding leads on each ward.

The trust set a target of 85% for completion of safeguarding training. In surgery, both medical and dental and qualified nursing staff met the target with 90% and 99% compliance overall.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>313</td>
<td>320</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>333</td>
<td>342</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>261</td>
<td>342</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>4</td>
<td>12</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>TOTAL</td>
<td>911</td>
<td>1,016</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical and dental staff met the target for two of the four safeguarding modules, but failed to meet the 85% target for level 2 and level 3 safeguarding children.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>528</td>
<td>528</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>554</td>
<td>554</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
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<td>85%</td>
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</tr>
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<td>1,649</td>
<td>99%</td>
<td>85%</td>
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</tr>
</tbody>
</table>
Qualified nursing staff met the target for three of the four safeguarding modules with 100% compliance in both level 1 safeguarding adults and level 1 safeguarding children. Staff failed to meet the 85% target for level 3 safeguarding children.

(Source: Routine Provider Information Request (RPIR) – Mandatory training)

Staff understood the broad principles of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), and staff knew how to get urgent advice.

**Cleanliness, infection control and hygiene**

There were systems in place to prevent and protect people from a healthcare-associated infection. Systems, processes and practices were developed, implemented and communicated to staff by managers and, in general, we observed good practice and clean wards and theatres. However, staff did not always ensure they complied with hand hygiene policies, and that ward areas and equipment were kept clean to prevent the spread of infection.

Staff kept equipment and premises visibly clean, complied with appropriate personal hygiene advice such as “bare below the elbows” and used control measures to prevent the spread of infection, such as wearing PPE.

Hand gelling facilities were available and were clearly signposted on the entrance to wards and clinical areas. Hand hygiene audits were completed on a monthly basis. The most recent months audit results were clearly displayed on each ward we visited on the ‘Welcome to the Ward’ board. For example, on D7 ward the current hand hygiene audit for that ward was 97.1%, and ward cleanliness was at 100%; and on E2 ward the March 2018 hand hygiene audit for that ward was 95.7%, and ward cleanliness was at 95%.

We observed that patients received healthcare from staff who decontaminated their hands immediately before and after every episode of direct contact or care. However, we saw two doctors on a ward round in E2 who did not wash or gel their hands between patients. In the same bay we also saw a health care assistant who, having taken vital readings from patients, did not wipe down the blood pressure cuff between patients or either wash or disinfect his hands. We also saw a doctor conducting a round on D7 ward who did not carry out hand hygiene between patients.

Wards and theatres were generally clean, tidy and well maintained though staff commented that wards in the older part of the hospital, such as E2 and E3, were more difficult to keep clean and fresh due to their age. A number of the patients we spoke to on the wards told us that their wards were clean.

At the last inspection in 2015 it was a compliance action that the surgical high care unit (SHCU) was risk-assessed for infection control risks. This was because there were no isolation rooms in the surgical high care unit for infectious patients. Furthermore, there were no toilets in the unit and there were only handwashing facilities in the middle of the unit. Its design was unsuitable as there was a clear and distinct risk of spreading infection to particularly vulnerable patients. On this inspection we identified exactly the same problems. The SHCU team told us that these issues were on the Trust’s risk register. At the time of the inspection the SHCU shared the sluice and toilets with E4 ward, which was next door to the SHCU. In the event of an infectious patient then they would be nursed at the end of the SHCU ward and that end of the ward would be screened off to provide a physical barrier.

Furniture was clean and generally in good condition. We occasionally saw the use of an ‘I am clean’ sticker to signify when equipment had been cleaned after use. We inspected commodes on
the wards and in recovery that had been disassembled for cleaning and then left for assembly for when next required so that staff knew that the commode had been cleaned. However, we saw other commodes that were assembled and may have been clean but there was nothing on the equipment to confirm that it had been cleaned after use.

In E2 ward, of the seven toilets we examined, three were flushed but dirty, one was not flushed, and three were visibly clean. We also spoke with two patients on E2 who told us of bed pans being left unemptied in toilets and then being told by staff to use another toilet. One patient on E2 told us that she asked a sister about hygiene and was told it was not her ward.

Patients were screened for MRSA in line with national guidance and this was documented in the patients’ records we observed. Nursing handover sheets had a column for infections and MRSA status and MRSA screening dates were detailed in that column.

Across the wards waste was managed safely, and there was safe disposal of sharp instruments. Clinical waste was segregated and disposed of safely and in accordance with trust guidelines. The contents of all sharp bins we saw were at a safe level with lids firmly closed.

The trust followed the guidance outlined in the management and decontamination of flexible endoscopes and operated a quality management system which complied with the requirements of ISO 13485:2016.

The trust managed the decontamination of reusable medical devices in line with national guidance such as the Department of Health Technical Memorandum on decontamination. We inspected the surgical equipment/instrument stores. Each store was laid out in a clean and detailed way. Checks of a random selection of individual Steri-packed surgical instruments revealed that a number had expired. The expiry dates ranged from January 2018 to 7 May 2018.

In Store 2 – General Instruments there were six out of date and one damaged wrap. In Store 3 – Trauma and Orthopaedic there were 41 instruments out of date; in Store 4 – Orthopaedic there was one K-Wire (implant) expired February 2018; in the ENT Store there were 5 instrument packs out of date, and in the ortho/trauma store there were five instrument packs out of date.

Theatres were visibly clean and tidy. Staff followed approved procedures to prevent cross infection and we observed staff carrying out cleaning and scrubbing procedures required during the theatre operations. However, in one theatre we observed a clinician wearing a ring with a mounted stone who scrubbed for an epidural wearing the ring, and during the procedure was not wearing a mask or visor, and was wearing jewelled drop earrings. In another theatre (12) we saw two used coffee cups on shelves in the scrub area.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

Facilities and surgical equipment which included resuscitation and anaesthetic equipment was fit for purpose and checked in line with professional guidance. We reviewed the anaesthetic machines and noted that the checks were recorded electronically and the information stored on the machine. All machines were in good order.

Equipment used for bariatric services was available from the medical equipment library store. The arrangements for managing waste and clinical specimens kept people safe. There were separate disposal bins for clinical and general waste and these bins were foot pedal operated. They were clean and not over-full. However, we observed two separate procedures in the operating theatres (maternity and theatre 16) where swabs were laid on top of an ‘inco’ sheet or
similar which was placed on top of a trolley. We did not see any evidence of where the used swabs were then collected, for example a rack, a plastic waste bag or other suitable container.

Resuscitation trolleys were accessible on all wards, and were checked daily. Electrical equipment was in date. Drugs were in two drugs boxes that were not secured to the trolley and which were sealed with a paper circular strip marked with the date.

Assessing and responding to patient risk

Staff had not completed and updated risk assessments for each patient. Comprehensive risk assessments had not always been carried out for people who used the services and risk management plans were not always developed in line with national guidance.

However, there was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.

Venous thromboembolism (VTE) rates were monitored and VTE was part of mandatory training for all staff. The trust’s compliance rate for VTE risk assessment was 95%. As at the 11th February only 75.2% of patients were assessed within surgery. We inspected, at random, five sets of notes on ward D7, two sets of notes on the Surgical Assessment Unit (SAU), and four sets of notes on the Surgical High Care Unit (SHCU). On Ward D7 for all five notes the VTE assessment had not been done. On the SAU one assessment had been done, the other was only partially completed. On SAU there was a daily `outstanding VTE and Dementia assessment` form in use which was taken to each days’ medical meeting. On SHCU three of the notes showed the VTE had been completed, on the fourth the VTE had been done indicating a risk to the patient but there was no detail as to what the risk was.

There was a Trust policy for sepsis management and the trust had developed and implemented a sepsis screening tool during 2017. Staff were aware of sepsis, sepsis screening policies and how to identify patient symptoms and were familiar with the Sepsis6 protocols. There was a clear escalation pathway for patients with presumed or confirmed sepsis and treatment was delivered to patients with presumed sepsis within the recommended sepsis pathway timelines.

Falls risk assessments were carried out for patients and where a risk of falls was identified then the falls prevention care plan was implemented. Patients who were a falls risk were flagged on the nursing handover sheet, and the ward information board displayed information on patient safety including days since the last fall.

Nursing staff carried out intentional rounding, which is a structured process whereby regular checks were carried out, usually hourly, of individual patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items. We saw documentation confirming this and patients we spoke with also confirmed that nurses regularly carried out checks on them.

The surgical assessment unit was the focal point for all general surgical referrals via GP, Emergency Department or Outpatients. It allowed for rapid assessment and diagnosis of the patient’s condition, prior to admission.

The day surgery unit saw approximately 50 to 70 patients per day. Patients were appropriately consented before admission and also on the day during pre-operative consultation. Patients were
required to be independently mobile with no requirement for hoisting. Therefore, there was no provision for bariatric patients.

It was a compliance action of the last inspection that there was compliance with the WHO Surgical Safety Checklist. The trust ensured compliance with the 5 steps to safer surgery, World Health Organisation (WHO) surgical checklist, by adopting a three staged audit. This included a documentation audit which was captured by an electronic patient monitoring system during the post-anaesthetic recovery period; a quantitative self-monitoring tool that audits whether all elements of the WHO checklist had been discussed and considered by the theatre teams; and the third was an observational audit carried out to review the quality of the WHO checklisting process.

The last observational audit was carried out on 12 April 2018. The results of their audit suggested that steps two to four (‘Sign In’, ‘Time Out’ and ‘Sign Out’) were always performed as part of the Five Steps to Safer Surgery, and that they were generally well embedded amongst the Theatre teams. Overall compliance with performing every element in the correct manner ranged between 95-97%.

We observed eight surgical procedures in theatres. For five of the procedures the WHO checklist was completed in full. For the other three, at one not all staff were present at the team brief and no debrief was conducted. At another the signout was done before the instrument count was carried out; and at another not all staff were present for the time out.

One further issue was noted during a gynaecological day case procedure; a vaginal pack was inserted and removed at the end of the operation but was not noted on the count board. This omission was indicative of poor theatre practice in monitoring and recording the use, recovery and disposal of surgical dressings.

We asked managers in theatres to confirm that Local Safety Standards for Invasive Procedures (LocSSIPs) using the National Safety Standards for Invasive Procedures (NatSSIPs) framework had been developed. There was some uncertainty as to whether the NatSSIPs framework had been used but managers were able to confirm that there were LocSSIPs for performance of the World Health Organisation (WHO) Surgical Safety Checklist, as well as for swab counts.

**Nurse staffing**

**Planned vs actual**

According to the figures provided by the hospital the service did not have enough nursing staff in surgery, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, patients on the surgical wards told us that they received good care, although some told us that the nurses were working at full capacity.

The trust has reported their staffing numbers below for nursing staff in surgery from April 2017 to March 2018.

Fill rates ranged between 90.5% to 93.3% during the period. As of March 2018, there were 52.6 fewer whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care.
<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate</th>
</tr>
</thead>
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<td>607.4</td>
<td>555.8</td>
<td>91.5%</td>
</tr>
<tr>
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<td>610.7</td>
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<td>July</td>
<td>611.3</td>
<td>561.3</td>
<td>91.8%</td>
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<tr>
<td>August</td>
<td>613.7</td>
<td>556.6</td>
<td>90.7%</td>
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<tr>
<td>September</td>
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<td>November</td>
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<tr>
<td>December</td>
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<td>566.1</td>
<td>92.5%</td>
</tr>
<tr>
<td>January</td>
<td>617.1</td>
<td>563.1</td>
<td>91.3%</td>
</tr>
<tr>
<td>February</td>
<td>617.2</td>
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<td>March</td>
<td>617.2</td>
<td>564.7</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request– Total staffing)

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017 the trust reported an annual vacancy rate of 13.7% for qualified nursing staff in surgery.

Nursing staff had a higher vacancy rate than the trust total of 7.3% for all staff groups.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

In December 2017 the trust reported a turnover rate of 12.3% for qualified nursing staff in surgery which is above the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported an annual sickness rate of 3.7% for qualified nursing staff in surgery, which is worse than the trust’s target sickness rate of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Planned vs actual

The trust has reported their staffing numbers below for medical and dental staff in surgery from April 2017 to March 2018. This suggests that the service did not have enough medical staff in surgery, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

Surgery is consultant delivered and led, and we saw medical staff carrying out ward rounds. The wards operate a ‘buddy’ system whereby ward staff can directly contact a clinician for support and advice.

Fill rates ranged between 91.6% to 97.0% during the period. As of March 2018, there were 23.1 fewer whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care.

<table>
<thead>
<tr>
<th>Month</th>
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<th>WTE actual in post</th>
<th>Fill rate</th>
</tr>
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<td>April</td>
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<td>349.8</td>
<td>93.7%</td>
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<td>May</td>
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<td>July</td>
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<td>372.1</td>
<td>347.5</td>
<td>93.4%</td>
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<tr>
<td>October</td>
<td>373.1</td>
<td>347.5</td>
<td>93.1%</td>
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<tr>
<td>November</td>
<td>377.1</td>
<td>345.9</td>
<td>91.7%</td>
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<tr>
<td>December</td>
<td>378.9</td>
<td>353.4</td>
<td>93.3%</td>
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<tr>
<td>January</td>
<td>378.9</td>
<td>352.8</td>
<td>93.1%</td>
</tr>
<tr>
<td>February</td>
<td>378.9</td>
<td>356.3</td>
<td>94.0%</td>
</tr>
<tr>
<td>March</td>
<td>379.0</td>
<td>355.9</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request– Total staffing)

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
From January 2017 to December 2017 the trust reported an annual vacancy rate of 2.9% for medical and dental staff in surgery. Medical and dental staff had a lower vacancy rate than the trust total of 7.3% for all staff groups.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

In December 2017 the trust reported a turnover rate of 6.3% for medical and dental staff in surgery which is below the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported an annual sickness rate of 1.2% for medical and dental staff in surgery, which is better than the trust’s target sickness rate of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we were awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was similar to the England average.
Staffing skill mix for whole time equivalent staff working at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tr>
<td>Consultant</td>
<td>57%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>10%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Records

Staff did not always keep detailed records of patients’ care and treatment. Records were inconsistent in that not all were clear, up-to-date and easily available to all staff providing care.

During this inspection we reviewed nine sets of patient’s notes and found that patient records varied in quality. Some records were fully completed covering all aspects of patient care, including enhanced care plans, full risk assessments, medicines reconciliations and discharge letters. Other records were missing significant detail. For example, in some there was no record of a falls assessments, a Venous Thromboembolism (VTE ) assessment, or MUST assessment (a MUST assessment is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese). Some of the care plans had not been completed. One record had a note of a PICC line but no renewal date; another note concerned two to four hourly checks on a patient with risk of pressure ulcer but which did not detail whether the checks had been done.

We also reviewed the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records for ten patients across four different wards. Again, while some records were fully detailed others were inconsistent in the detail provided.

People’s individual care records were typically in three sets: a document folder, a folder for nurses’ care plans and risk assessments, and a clip board for drug and fluid charts. Depending on the ward these records were kept in an unlocked trolley, an unlocked drop file drawer within the trolley, at the foot of the patient’s bed, or in shelving in the ward or bay. They were not held securely, to protect people’s confidentiality, and could be accessed by unauthorised persons.

Medicines

Medicines were stored securely and storage areas were kept clean and tidy. Though staff monitored fridge temperatures, including minimum and maximum temperatures, it was not possible to confirm whether medicines were stored in the recommended temperature range, as not all of the fridge temperatures were correct. Staff were aware and would log a report with the facilities company who were responsible for fridge maintenance.
Controlled drugs (CD) were stored and managed appropriately. We reviewed the CD registers and found they were correctly filled out and signed.

However we did find that on some wards there was out of date insulin. We also found there were controlled drugs still in stock on the ward prescribed to patients who had since been discharged. These drugs had not been collected and removed by pharmacy. On one ward there were controlled drugs in stock that had been issued to ten patients who had since been discharged. We inspected the controlled drug stores on the wards while in the presence of a member of the ward staff and we raised these issues at the time.

Incidents

The service managed patient safety incidents well across the two service centres, however there were concerns about the safety culture in theatres. This was due to the repeat occurrences of similar never events within the operating theatres as detailed below in Never Events.

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Governance, including serious incidents requiring investigation (SIRI’s) were a standing item on the CSC Board agendas. The trust told us each CSC produced a newsletter outlining key messages and lessons learnt from SIRIs within their service centre and hold governance meeting on a monthly basis where these are also discussed. On our inspection we saw an example of this newsletter. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported three incidents classified as never events for surgery.

- Two surgical/invasive procedures meeting SI criteria; one wrong site surgery in March 2017 and one retained foreign object post procedure in October 2017.
- One operation/treatment given without valid consent in August 2017.

(Source: Strategic Executive Information System (STEIS))

A further never event occurred in April 2018. This was wrong site surgery, stent insertion. We have also commented on observed poor practice with surgical dressings above in assessing and responding to patient risk.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 40 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from February 2017 to January 2018.

A breakdown of the incident types is shown below:

- Eight surgical/invasive procedure incidents meeting SI criteria (20%)
- Seven slips/trips/falls meeting SI criteria (17.5%)
- Six diagnostic incidents including delay meeting SI criteria (including failure to act on test results) (15%)
- Five pressure ulcers meeting SI criteria (12.5%)
Four sub-optimal care of the deteriorating patient meeting SI criteria (10%)
Three HCAI/Infection control incidents meeting SI criteria (7.5%)
Three incidents pending review (7.5%)
Two medication incidents meeting SI criteria (5%)
One treatment delay meeting SI criteria (2.5%)
One operation/treatment given without valid consent. (2.5%)
(Source: Strategic Executive Information System (STEIS))

Safety thermometer

Staff collected safety information and shared it with staff, patients and visitors. The service used the safety monitoring results and managers used this to improve the service. There was evidence on the surgical wards of falls monitoring, falls plans for patients at risk, pressure ulcer monitoring, and checks on urinary catheters.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 11 new pressure ulcers, 11 falls with harm and 11 new catheter urinary tract infections from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Portsmouth Hospitals NHS Trust

![Graph showing prevalence rate of pressure ulcers, falls, and catheter urinary tract infections](image-url)
There was a weekly Surgical Quality Assurance Meeting at which mortality and morbidity issues were discussed. There had been a decrease in the rolling 12 month hospital standardised mortality ratios (HSMR) rate in December 2017 to 108.2 (111.3 to November 2017) which, nationally, places the trust in the average `deaths which were as expected` constituency.

The duty of candour is a regulatory duty. Within the trust it was part of the undergraduate medical curriculum and was re-emphasised at the induction of junior medical staff and included in a number of different specialty training programmes including foundation. There was a duty of candour and Being Open Policy and posters describing duty of candour requirements provided to clinical service centres for display in staff areas. Heads of Nursing, matrons and governance leads were trained in duty of candour requirements and this was cascaded to ward staff.

Staff we spoke with understood their responsibilities in relation to duty of candour and understood it was about being open and transparent when things went wrong. Between January to December 2017 the duty of candour had been applied 64 times across surgery.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Care and treatment was delivered in line with evidence based guidelines, including from the Royal College of Surgeons, the Royal College of Anaesthetists, and the National Institute for Health and Care Excellence (NICE) guidelines. Staff could access these policies on the provider’s intranet.

The service also took part in clinical audits to measure the effectiveness of the care and treatment provided. This included the National Emergency Laparotomy Audit (NELA) 2017; the National Bowel Cancer Audit (2017) and the 2017 National Hip Fracture Database. Audit findings were used to inform practice and improve the quality of patient care received in the unit.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients’ religious, cultural and other preferences.

There were specialist diet choices available. For example, meals suitable for people with diabetes, for gluten free diets, or textured meals for patients with dysphagia conditions. There were also meals suitable for people’s cultural and dietary wishes, for example halal and vegan menus.

Patients told us they liked the food and there numerous compliments from the people we interviewed.

Staff offered support to those patients who needed help or who had dietary restrictions. Those patients were identified with the issue of a red tray at meal times. This was also indicated on the nursing handover sheet. For example, one note read: ‘Red tray – soft diet and stage1 fluids.’

The trust self-assessments reported they were fully compliant with the ‘10 characteristics of good nutritional care’ (Nutrition Alliance), the British Diabetic Association guidance on menu planning, and the use of a validated nutritional screening tool to identify patients at risk of malnutrition.

Staff assessed patients’ nutritional status using a screening tool.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. Pain was assessed using the Abbey Pain Assessment Scale, which included observing the patient and identifying any behaviour that indicated pain. One patient told us that the nurses could see he was in pain before he felt the need to call them and would come over to his bed to see what support they could give him. Staff had access to the acute pain team on site. Patients we spoke with told us they were comfortable and that staff regularly checked to see if they required pain relief. Also, during intentional rounding on the wards staff asked patients about their pain.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust told us that each national audit published from the National Clinical Audit and Patient Outcomes Programme and NHS England Quality Account List was reviewed by the appropriate specialty lead; a review of results and summary report was expected within 4 weeks of publication. In turn that was reviewed by the Trust Clinical Effectiveness Steering Group (CESG) chaired by
the Medical Director. The summary report contained details of areas of good practice, areas of concern, risks and any immediate actions required. Through this process the Trust had identified services which demonstrated good patient outcomes that could be evidenced by the benchmarks published nationally. Examples included the National Hip Fracture and the National Heart Failure Audit.

Relative risk of readmission
Queen Alexandra Hospital: Elective Admissions

From November 2016 to October 2017 all patients at Queen Alexandra Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Ophthalmology and ENT patients at Queen Alexandra Hospital had a lower expected risk of readmission for elective admissions when compared to the England average, whilst upper gastrointestinal surgery patients had a higher expected risk of readmission when compared to the England average.

Queen Alexandra Hospital: Non-Elective Admissions

From November 2016 to October 2017 all patients at Queen Alexandra Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Colorectal surgery, upper gastrointestinal and general surgery patients at Queen Alexandra Hospital all had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

(Source: HES - Readmissions (01/11/2016 - 31/10/2017))

National Hip Fracture Database
In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 4.5% which was better than expected. The 2016 figure was 4.9%.

The proportion of patients having surgery on the day of or day after admission was 80.3%, which was worse than the national aspirational standard of 85%. However, the 2016 figure was 82.1%
which indicated a further reduction in the ability of the trust to provide timely surgery to patients after admission.

The perioperative medical assessment rate was 100%, which met the national aspirational standard of 100%. The 2016 figure was 99.9%.

The proportion of patients not developing pressure ulcers was 99.1%, which falls in the top 25% of trusts. The 2016 figure was 98.9%.

The length of stay was 18.2 days, which falls in the middle 50% of trusts. The 2016 figure was 18.7 days.

(Source: National Hip Fracture Database 2017)

National Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 67.4% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate.

The risk-adjusted 90-day post-operative mortality rate was 2.8% which was within the expected range. The 2016 figure was 4.6%

The risk-adjusted 2-year post-operative mortality rate was 15.5% which was within the expected range. The 2016 figure was 11.6%.

The risk-adjusted 30-day unplanned readmission rate was 8.5% which was within the expected range. The 2016 figure wasn’t reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 43.9% which was better than expected. The 2016 figure was 36.2%.

(Source: National Bowel Cancer Audit 2017)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 14.7%. Patients diagnosed after an emergency admission were significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 17%.

The 90-day post-operative mortality rate was 4.1% which was within the expected range. The 2015 rate was 5.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40.1%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2017 National Emergency Laparotomy Audit (NELA), the Queen Alexandra Hospital achieved between 50% and 80% which is an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 305 cases.

The Queen Alexandra Hospital achieved between 50% and 80% which is an amber rating for the
crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 244 cases.

The Queen Alexandra Hospital achieved higher than 80% which is a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 173 cases.

The Queen Alexandra Hospital achieved between 50% and 80% which is an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 123 cases.

The risk-adjusted 30-day mortality for the Queen Alexandra Hospital was within expectations, based on 305 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients were asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was slightly better than the England average with a higher proportion of patients reporting improvement in both groin hernia EQ VAS and the EQ-5D index than the England average.

For hip and knee replacements, performance was about the same as the England average. There was no data available for varicose veins.

(Source: NHS Digital)
Competent staff

Appraisal rates
From April 2017 to March 2018, 81% of staff within surgery at the trust had received an appraisal which did not meet the trust target of 85%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Non-Medical Staff</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>341</td>
<td>327</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>158</td>
<td>132</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>349</td>
<td>273</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>534</td>
<td>407</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>215</td>
<td>159</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>23</td>
<td>12</td>
<td>52%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,623</td>
<td>1,313</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff and other non-medical staff were the only two staff groups who achieved the 85% target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The service had not ensured that all staff were fully competent for their roles. Managers had not fully appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Managers across the trust were provided access to a weekly HR Dashboard which enabled them to see the appraisal compliance for their ward areas, including a weekly list of staff that were compliant, non-compliant or due to expire in the next 3 months. Nurse ward managers we spoke to knew what their appraisal rates for their wards were, for example 88% on SAU, and where they were below target what actions they needed to undertake to reach the standard. For example on D7 ward, which had a rate of 47% at the time of the inspection, 12 members of staff had been booked in for appraisals.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Collaborative multidisciplinary working took place in surgical clinical services. Nursing handover sheets flagged up those patients for whom there was an MDT meeting. These meetings discussed the pre-and post-operative plan, the treatment plan, and the patient pathway. Surgical and nursing staff discussed daily ward rounds together with physiotherapists and occupational therapists. We observed pharmacists on the wards working with nursing and medical colleagues.

We also met on the surgical wards colleagues from social services who worked with hospital services to identify and support those patients who needed to be in a home or cared for environment.
The trust told us that there were very close working relationships, both at medical and nursing level, for example, between endocrine/thyroid/parathyroid surgery, endocrinology and head and neck surgery and also between breast and plastic surgery, where there were joint operating lists.

**Seven-day services**

Acute and emergency surgical services were available seven days a week across the trust. Some planned elective procedures were available on a weekend, for example to deal with back logs in specialities such as lower GI surgery. There were no plans to develop a seven day surgical service.

The surgical wards operated a buddy system for outlied patients whereby they had a specific bleep number to call 24/7 should they need clinical advice and support.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty training. In surgery, medical and dental staff failed to meet the target with 84% compliance overall for the four relevant training modules. Qualified nursing staff met the target with 94% compliance overall.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>321</td>
<td>342</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>321</td>
<td>342</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>158</td>
<td>232</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>94</td>
<td>145</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>894</strong></td>
<td><strong>1,061</strong></td>
<td><strong>84%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>547</td>
<td>554</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>547</td>
<td>554</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>273</td>
<td>298</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>451</td>
<td>526</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,818</strong></td>
<td><strong>1,932</strong></td>
<td><strong>94%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory training)

We also reviewed the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records for ten
patients on wards D7, E2 and E3 and SHCU. These were inconsistent in detail provided. On one record DNACPR had been agreed by the patient’s wife as the patient lacked capacity. In the patient’s note’s there were entries showing that he had dementia but that he had also consented to treatment. However, there was no MCA assessment. When asked whether the patient had capacity the inspector was told that it ‘fluctuates’.

On SHCU we looked at the notes of a patient who had a DNACPR in force. The DNACPR form was signed by a consultant on the 1 April 2018, the decision based on the patient’s condition and infirmity. The patient had not been informed or had agreed to the decision. However, a relative had been contacted who said that she wouldn’t want the patient to go through CPR but could not account for the rest of the family’s views so would discuss with them and contact the ward later that day. There was no further record in the notes from the family. Two weeks later in her notes there was a written capacity assessment showing she had capacity but the original DNACPR had not been amended or reissued. On the day of the inspection (18 May 2018) we asked whether the patient in question had capacity and were categorically informed that she did. This concurred with our observations of the patient. We asked whether the patient had been told of the DNACPR decision and were told this had not happened. The ward manager was intending to address this immediately.

On E2 ward there was a Deprivation of Liberty Safeguard assessment for a seven day urgent authorisation which had expired. The DOLS form was a photocopy of a form which had a pre-typed Standard Authorisation. This authorisation was not personalised to the patient. In fact, the text referred to a different ward and the text at some points referred to ‘she’ although the patient was male. There was no MCA assessment done at the time of the DOLS. Consent Form 4 for this patient was not completed correctly. Section B: assessment of patient’s capacity had the following entry: ‘consultant authorised this procedure.’ Section D: involvement of the patient’s family was blank though the patient had a wife who was contactable.

It was condition of the 2015 inspection that: ‘Do not attempt cardiopulmonary resuscitation forms are completed appropriately and mental capacity assessments, where relevant, are always performed.’

It was the trust’s policy to conduct a two stage consent process for elective procedures and, where practicable, for emergency procedures as well. The two stage consent process was commenced at the pre-assessment clinics for routine elective surgery, or was documented and then checked in the event of an emergency procedure. During observations of surgical procedures we found that practitioners were complying with their policy.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with 45 patients. All the patients told us that staff treated them well and with kindness. On D8 ward we were told that “care is brilliant”. On D7 ward a patient told us that she had experienced “the best care in the world”. A male patient on E3 ward told us: “this is the best ward and hospital” and he also told us that the staff allowed him his independence but were always there to help. However, we did receive comments from patients expressing concerns that they saw too many different doctors and as a result could not easily keep up with what was happening to their care.

A patient on D4 and a patient on D5 told us they were listened to and treated with respect and dignity. However, on D7 ward we observed a ward round in one of the two four-bedded bays. Individual patient’s nutritional assessments and diagnoses were discussed at the end of each patient’s bed and the discussions were easily overheard thereby not ensuring privacy and dignity. However, the clinical staff did step out of the bay to discuss in confidence the safeguarding issues of a specific patient.

There were no single sex breaches on the wards at the time of the inspection. However, to ensure dignity and privacy for men and women in the surgical high care unit it was necessary for men and women to occupy separate areas at either end of the ward and privacy was only ensured with portable screens that went across the unit. This was due to the layout of the ward, an issue that was raised at the last inspection.

Friends and Family test performance

From December 2016 to November 2017 the friends and family test response rate for surgery at Queen Alexandra Hospital was 38% which was better than the England average of 29%.

A breakdown of percentage recommended by ward is shown below:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Resp.</th>
<th>Ave Resp. Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>515</td>
<td>62%</td>
</tr>
<tr>
<td>D4</td>
<td>453</td>
<td>67%</td>
</tr>
<tr>
<td>D5</td>
<td>1253</td>
<td>51%</td>
</tr>
<tr>
<td>D6</td>
<td>374</td>
<td>80%</td>
</tr>
<tr>
<td>D7</td>
<td>675</td>
<td>39%</td>
</tr>
<tr>
<td>D8</td>
<td>746</td>
<td>14%</td>
</tr>
<tr>
<td>D9</td>
<td>5373</td>
<td>36%</td>
</tr>
<tr>
<td>D10</td>
<td>1168</td>
<td>21%</td>
</tr>
<tr>
<td>D2</td>
<td>659</td>
<td>44%</td>
</tr>
<tr>
<td>D3</td>
<td>77</td>
<td>66%</td>
</tr>
<tr>
<td>D4</td>
<td>2364</td>
<td>28%</td>
</tr>
<tr>
<td>D5</td>
<td>638</td>
<td>32%</td>
</tr>
<tr>
<td>Surgical High Care</td>
<td>111</td>
<td>130%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress. We had positive feedback from a patient on E3 ward who said that the nurses were so attentive they could recognise when he was in pain and would respond to his distress without him having to summon them. On D5 ward a patient and the patient’s daughter were concerned about bleeding from the surgical area. A
consultant and nurse attended and changed the bandages and reassured the patient that bleeding was normal post-operation. The patient and the patients’ daughter were happy and reassured by the explanation. On D4 ward a patient told us the nurses provided “a shoulder to cry on when needed.” Staff in operating theatres were observed to be providing reassurance and comfort to patients as they were waiting for their anaesthetics. We observed a priest providing reassurance and comfort to patients in wards on E3.

Overall patients told us repeatedly of being listened to, of feeling that their concerns were understood and that they were valued.

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

Staff involved patients and those close to them in decisions about their care and treatment. We spoke in depth with 35 patients and two relatives. The patients all said they understood the care they were receiving, with comments such as: “very good care, listening and explaining”; “I have been listened to, and things explained”; “they confirm you understand” and “I understand why I have had to wait for my meds”. On D6 a patient told us: “I’ve had more attention than I deserve, listening and explaining.”

In the operating theatres before anaesthetics we observed staff explaining in easy to understand terms what was about to happen and visibly reassuring the patients.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Patients entering their clinical care pathway through the surgical assessment unit had their needs assessed including assessments of specific risks.

The trust provides interpreters services. We observed a patient on D7 who required an interpreter on that day. This service request was booked by telephone. Staff were aware of the need to ensure that the patient had direct access to the interpreter without the involvement of the family due to clinical issues with that patient.

Meeting people’s individual needs

In general, the service took account of patients’ individual needs and were aware of the needs of their patients. For example, on D7 ward there was a vulnerable adult’s board with ‘This is Me’ leaflets, Forget Me Not stickers and magnets, falls aware stickers and information on safeguarding.

Each ward had a dementia champion and there were symbols, such as the Forget Me Not stickers, and leaflets, such as This is Me to help people and their relatives. However, whilst there were prompts as described available across the surgical wards we did not see these consistently in use across these wards. While staff were aware of which patients were living with dementia we did not see evidence that dementia care was fully embedded in the way the wards carried out their day to day activities.

Social services provided outreach staff to work in the hospital in order to assist with safe and secure discharge planning.

Bariatric patients were provided with the right equipment from the medical equipment library.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Average length of stay

Queen Alexandra Hospital: Elective average length of stay

Note: Top three specialties for specific trust based on count of activity.

From December 2016 to November 2017:

- The average length of stay for all elective patients at Queen Alexandra Hospital was 4.1 days, which is slightly higher than the England average of 3.9 days.
- Average length of stay for trauma and orthopaedics elective patients was higher than the England average.
- Average length of stay for ENT and urology elective patients was similar to the England
The average length of stay for all non-elective patients at Queen Alexandra Hospital was 5.4 days, which is slightly higher than the England average of 5.0 days.

Average length of stay for trauma and orthopaedics non-elective patients was higher than the England average.

Average length of stay for colorectal and upper gastrointestinal surgery patients was lower than the England average.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery had been consistently better than the England average, ranging from 73% to 79% compared to the England average range of 69% to 72%.

In December 2017 76% of patients were treated within 18 weeks compared to the England average of 72%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, four of the specialties were above the England average, two were in line with the England average and one below.
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>93.3%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85.7%</td>
<td>72.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>84.5%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>81.1%</td>
<td>64.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>72.6%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>68.5%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>61.8%</td>
<td>61.4%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>NA</td>
<td>82.9%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>NA</td>
<td>70.7%</td>
</tr>
</tbody>
</table>

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From Q4 2015/16 to Q3 2017/18 the trust has consistently had a lower proportion of cancelled operations that were not treated within 28 days than the England average, with the highest proportion seen in Q4 2015/16 with 6%, improving to 0% in three of the quarters in the period.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Portsmouth Hospitals NHS Trust**

Over the two years, the number of cancelled operations as a percentage of elective admissions at the trust had fluctuated. Q4 2015/16 to Q2 2016/17 was generally in line with the England average, however Q3 2016/17 saw a decline in performance with the number of cancelled
operations increasing above the England average, peaking in Q4 2016/17, before seeing an improvement from Q1 2017/18 where performance began to fall more in line with the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

At the time of the inspection theatre utilisation was at 87%.

Between October 2017 and March 2018 there had only been one cancellation of a list, which was an ENT list for the 18 January 2018 due to outlying patients in recovery overnight. This concerned four paediatric cases, all of whom were re-booked within the constitutional standard of the 18 weeks pathway.

At the time of the inspection there was only one patient waiting in excess of 52 weeks for their operation. There was an extended wait for the patient to be seen and then for diagnostics at 49 weeks. It was decided surgical intervention was required and the patient was offered treatment within 52 weeks but declined. A date for the procedure was agreed beyond 52 weeks.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of complaints

From January 2017 to December 2017 there were 43 complaints about surgery (7% of total complaints received by the trust). The trust took an average of 35 working days to investigate and close complaints; this is slightly longer than the time set out in their complaints policy which states all complaints should be closed within 30 working days.

Clinical treatment was the main subject of complaint with 58% of complaints relating to this. The table below shows a breakdown of complaints by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>25</td>
</tr>
<tr>
<td>Inpatient delays &amp; cancellations</td>
<td>9</td>
</tr>
<tr>
<td>Admission, discharge &amp; transfer</td>
<td>3</td>
</tr>
<tr>
<td>Hospital acquired infection</td>
<td>1</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>1</td>
</tr>
<tr>
<td>Patient property / expenses</td>
<td>1</td>
</tr>
<tr>
<td>Personal records</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Consent to treatment</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)
The trust told us that staff within the clinical service centres (CSC) were encouraged to try to resolve any concerns or complaints which come to their attention at ward/departmental level. Staff were also advised to log these onto the feedback module of the Datix reporting system and to ensure that complainants were informed they could contact PALS or the complaints team if they wished to pursue the matter further.

We spoke to a manager on D7 ward who told us that, in the event of a complaint, the nurse in charge would talk to the patient and the family and try and resolve the matter at ward level. They would also advise them of the PALS service, and would provide a PALS leaflet, and advise them of the trust’s complaints procedure. PALS leaflets were available on the wards.

A patient on E3 ward told us that her partner had complained about her treatment and she had been visited on the ward by the director of nursing to discuss the matter.

Complaints and learning from complaints were formally discussed at governance meetings, at the governance item section of the CSC board meetings and at MRM (Mortality and Morbidity) meetings. Learning opportunities from complaints were also discussed at team meetings and nursing handovers, where appropriate.

### Is the service well-led?

**Leadership**

The trust had been through a number of changes at executive level and the new chief executive and director of nursing had made a significant impact. Staff at all levels told us they had seen or met the chief executive and the director of nursing and had noticed a positive change in leadership style.

The management teams for the two clinical service centres were slightly different in structure but followed the same model of: a general manager, a head of nursing, service clinical leads, matrons and a business manager. The surgical and cancer CSC (CSC) included senior colleagues from the Defence Medical Group (South).

We met with senior managers from the two CSC’s and asked how the new executive had affected their local decision making. The managers explained how the planning process had become very transparent for budgets and service planning and, as a result, had been much more productive. We also had comments from senior managers describing a more empowered decision making process. They gave an example where a recent decision had been made to cancel orthopaedic lists to better manage winter pressures. This decision had been made through a joint planning exercise. The chief executive committed to the ward reopening in 10 weeks which it did. This had created a sense of confidence in the leadership provided by the executive.

The trust provided care to serving military personnel and had military medical and nursing staff working within surgery clinical services centre. Both military and civilian staff told us this relationship worked extremely well, and from our observations on the wards this did seem to be the case.

Staff told us they felt supported by their managers and were generally positive about the leadership of the trust, with leaders being much more visible at all levels. The only dissenting note was from senior nurse ward managers whose job plan was intended for them to spend 90% of their time on management duties for example, staff appraisals, risk management, and so forth, but
found that due to staff pressures they were spending most of their duty time `in the numbers` providing nursing care.

**Vision and strategy**

The trust was in the process of developing a new vision for what it wanted to achieve together with workable plans to turn it into action. This was being developed with involvement from staff we spoke with.

At the time of the inspection, the surgical clinical services centre had completed their strategic business plan for 2018/19 which was focused on operational delivery, finance and investment, workforce and productivity.

**Culture**

Most staff we spoke with felt that managers in the trust promoted a positive culture that supported and valued the staff, and that there was a sense of common purpose based on shared values.

Staff on the surgical CSC and in Theatres were proud to work at the hospital. However, at the time of the inspection, a number of ward based staff told us they were concerned about staff numbers available to meet the demand. This view was shared by managers in surgery and theatres.

We observed kind and compassionate, patient focused care and feedback we had directly from patients confirmed that there was a strong culture of caring and supporting patients in the surgical wards.

We asked staff about the duty of candour. Most staff were familiar with it and were able to tell us what it meant in practice.

**Governance**

On the surgical CSC there was a monthly board meeting at which governance was a scheduled item, and there was a weekly surgical quality assurance meeting that included a morbidity and mortality review. We examined recent minutes from these meetings and noted that areas of risk, learning and actions to improve patient safety were discussed. There was a separate surgical governance meeting held every six weeks.

On D7 ward they told us they had a meeting on safeguarding and deprivation of liberty standards (DoLS) every Monday morning and a band 7 senior nurses development day every month at which governance issues were discussed.

In Theatres there were nine clinical governance mornings rostered per annum which covered learning from incidents, training and new updates.

**Management of risk, issues and performance**

The trust was in the process of developing its systems for identifying risks. The trust told us enhanced training in risk management would be delivered during 2018 to ensure that all parts of the organisation had a better understanding of the importance of effective risk management. We found that the risk register was either not fully relevant to current risks, or did not accurately reflect real risks.

Currently, high level risks reported to the trust for anaesthetics and theatres included:

Outlied patients in Recovery overnight. This was the highest risk and was opened in 2015 and reviewed in January 2018. However, on our inspection we were told this was a very rare occurrence and not a particular risk.
Lack of anaesthetic trainees and gaps in on-call rota. This risk was opened in June 2017.

In surgery of the six high level risks reported to the trust included the following:

Patient harm and staff health and well-being impacts as a result of working conditions in dispensary on E level, opened in 2017

Staff moves from Surgery CSC, opened in 2017.

Of the six reported this did not include MCA/DOLS compliance, which was a risk opened December 2017 on the Surgery & Cancer CSC Risk Register. This risk was rated as a Low risk which did not accord with our findings.

The WHO checklist was not always fully complied with.

On Surgery CSC risks were discussed at the monthly risk register meeting.

At nursing handover meetings patient risks should be discussed, but we did not observe such discussions in respect of patients who were a falls risk or DNAR. However, those details were on the nursing handover sheets.

Patient safety performance was displayed on the `welcome to the ward' board which detailed number of days since the last incident of c.diff, MRSA, pressure ulcer and fall.

**Information management**

The trust collected, analysed and used information well to support all its activities, using secure electronic systems with security safeguards.

Managers attended a monthly information governance and data quality meeting.

As yet, there was no strategy for moving towards electronic patient records. This was recognised at executive level and was a strategic objective for the future.

Information Governance Issues and Compliance Framework was a standard agenda item on the surgery clinical service centre governance meeting.

Staff were familiar in the use of computers for training, HR, and appraisals and aware of the data security requirements.

**Engagement**

The surgery CSC engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There were good working relationships with military clinicians and nurses who were fully embedded in to the surgery CSC. Hampshire social services had outreach staff working directly within surgery wards to assist in identifying and preparing patients for suitable discharge.

For the 2016 staff survey, the surgery CSC was one of the most improved, and one of the CSC’s which benchmarked higher than the overall trust engagement score. The CHAT CSC, which includes theatres and anaesthetics, was one of the CSC’s that benchmarked lower than the overall trust engagement score.

Patients were invited to comment on the care they received through the NHS Friends and Family test. We saw feedback cards were available in surgical wards. Friends and family test results, as well as the outcomes of complaints, were shown on the ‘welcome to the ward’ board.
Learning, continuous improvement and innovation

The surgery CSC was committed to improving services by learning from when things went well and from when they went wrong, promoting training, research and innovation.

The CSC had taken part in a number of national audits including the National Emergency Laparotomy Audit (NELA) 2017; the National Bowel Cancer Audit (2017) and the 2017 National Hip Fracture Database

In Anaesthetics there had been the following developments:

- perioperative medicine with the 'surgery school' project
- Standard Operating Procedures for patients with learning difficulties
- Nerve Block service for all patients rib fractures

And in Theatres

- a new care plan introduced for recovery incorporating handover checklist
- an Activity Tracker introduced to follow the patient through their theatre journey
- Introduction of Vitalpac in recovery allowing recording of observations and assessments
- An alternative admission pathway through recovery for some orthopaedic patients
- And the creation of specific training team for orthopaedic scrub.

In 2016 the CSC had a report from the Deanery giving them a red rating. The CSC developed a new improvement plan and their latest Deanery rating had now risen to a green.

At ward level learning was embedded. Incidents and learning from them were discussed at daily handover, and at ward management meetings audit results were discussed such as infection prevention, Braden scale pressure ulcer results and nursing care plans.

The trust also presents annual `Best People` awards to acknowledge those members of staff that had gone above and beyond in their roles across the hospital.
Facts and data about this service

The trust has 24 critical care beds across two adjoining units. Each unit has nine open beds and three side rooms. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Portsmouth Hospitals NHS Trust and England.

This trust

- Neonatal: 42.4%
- Adult: 57.6%

England

- Neonatal: 7.9%
- Adult: 92.1%

(Source: NHS England)

The trust has 11 clinical service centres (CSC) with Critical care sitting in the Critical Care, Hospital Sterilisation and Disinfection Unit, Dept of Anaesthesia and Theatres (CHAT) clinical service centre.

The trust’s critical care service included a 24 bedded intensive care unit (ICU) and a critical care outreach service. The ICU included support from the critical care follow up team, the specialist nurse organ donation team and the bereavement support team. Neonatal critical care was reported in the children and young people’s report.

The ICU has about 1500 admissions per year.

During our inspection, we spoke with 50 members of staff. This included the Clinical Director for critical care, the Matron and operational manager, junior and senior medical staff, trainee advanced critical care practitioners, junior and senior nursing staff, a physiotherapist, a pharmacist, a dietitian, administration staff and housekeeping staff. We spoke with three patients and three relatives. We observed care and treatment patients were receiving and reviewed six patient records.

Before and after the inspection we reviewed performance information from and about the critical care service.

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 85% for completion of mandatory training, with the exception of Information Governance which had a 95% completion target.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for medical/dental staff is shown below:
The overall completion rate for medical and dental staff was 83%. Ten of the 17 modules met the trust target with five modules having a 100% completion rate.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>143</td>
<td>143</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>142</td>
<td>143</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>142</td>
<td>143</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>142</td>
<td>143</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>142</td>
<td>143</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>142</td>
<td>143</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>140</td>
<td>143</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>140</td>
<td>143</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>134</td>
<td>137</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>134</td>
<td>137</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>133</td>
<td>143</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>110</td>
<td>136</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall completion rate for nursing and midwifery staff was 88%. 11 of the 16 modules met the trust target with one of the modules having a 100% completion rate.  

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Data supplied was from April 2017 – Jan 2018 therefore there were still several months of the financial year for mandatory training courses to be completed.

New starters who were currently working through the mandatory training programme had an impact on the compliance figures.

Mandatory training records were held electronically. There was a process to flag up when staff’s training was about to expire.

Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning. The critical care unit provided much of the face to face learning in the unit and had invested in a train the trainer program, for example manual handling and fire safety training, this meant that it was easier for staff to access the training.

Staff we spoke with knew how to access mandatory training and explained how the hospital computer system would flag up any outstanding training or updates that were required.

The Clinical Service Centre education team and senior staff in the unit explained how they monitored staff’s mandatory training compliance and would email staff if training was required. This was confirmed by team members we spoke with.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Staff Eligible</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>29</td>
<td>29</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>35</td>
<td>35</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>28</td>
<td>35</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff was 93%. The trust target was met for two of the three safeguarding modules.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Staff eligible</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>142</td>
<td>143</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The overall completion rate for nursing and midwifery staff was 98%. The trust target was met for all of the safeguarding modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training) Data supplied was from April 2017 – Jan 2018 therefore there were still several months of the financial year for safeguarding training courses to be completed.

Staff at all levels knew how to recognise and report safeguarding issues. Staff were able to demonstrate to us how to access safeguarding policies and procedures on the trust’s intranet and whom to contact if they had a safeguarding concern.

The critical care unit had a designated safeguarding lead whom we spoke with. They explained how the role worked in the unit, from them being the point of contact for the team, training staff and reviewing and reporting on safeguarding issues to the trust’s head of safeguarding. All staff we spoke with could tell us who the safeguarding lead was for the unit.

Information on safeguarding issues was displayed on the dedicated safeguarding notice board which was visible to patients, visitors and staff. The information displayed included the types of abuse, including female genital mutilation (FGM), who to contact if abuse was suspected or seen and the law and adult safeguarding.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used controlled measures to prevent the spread of infection.

Cleaning of the unit was subcontracted to another provider. The critical care unit had three dedicated cleaners. We were told by the cleaning staff that this gave them ownership for the area they worked in and helped develop good relationships with staff, patients and visitors.

We saw cleaning staff on the unit every day during the inspection and our observations showed a meticulously clean clinical environment.

We reviewed other areas of the critical care unit, such as the reception office, meeting rooms and the relatives waiting area and also found them to be visibly clean and tidy.

We reviewed clinical equipment and noted these to be clean and labelled with green ‘I am clean’ stickers on them, detailing the date and time they were last cleaned.

We saw evidence that cleaning audits were carried out on the critical care unit and who was responsible if cleaning standards fell below certain levels. The cleaning audits we reviewed showed 100% compliance to the standards.

Rates for hospital acquired infections were low. Data from the trust showed there had been no unit-acquired MRSA bacteraemia since 12th November 2012. There had been six cases of c.difficile reported in the CHAT clinical service centre from Apr 2017 to Mar 2018. However, from the data received from the trust we could not tell if this was in the critical care service.

Data from the Intensive Care National Audit and Research Centre (ICNARC) detailed that rates of unit-acquired MRSA bacteraemia and blood-borne infections were less than those of similar critical care units.
The unit had side rooms with lobbies and airflow systems to help prevent the spread of infection from infectious patients or to protect patients with altered immune systems.

We observed all staff who had interactions with patients followed the trust’s policy and national best practice guidelines, with arms bare below the elbows, washing hands between each patient contact and using personal protective equipment such as gloves, aprons and protective face masks.

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 patients. During our inspection we saw that staff followed this practice.

The critical care unit used the Portsmouth hand hygiene tool to audit key areas of infection control; appearance of staff, hand hygiene, and protective equipment. We saw displayed in the critical care unit the results from February 2018’s audit, which showed 100% compliance with the trust’s policy.

We observed nursing staff at shift changeover carrying out the daily bedside cleaning checklist.

Throughout critical care there were posters telling visitors about the critical care visitors charter. These were a set of six guidelines to help fight infections and maintain a safe secure environment. They included things like; asking visitors not to visit loved ones if feeling unwell or had sickness or diarrhoea in the last 48hrs and to take home surplus patient belongings so bed areas could be cleaned easier.

Visitors to the critical care unit were requested to clean their hands before and after visiting the patient. They were advised of this verbally by staff, by posters displayed throughout the unit and in information leaflets either specifically about hand hygiene or in detailed leaflets about the critical care unit.

Hand sanitiser gel was available at the entrance and throughout the critical care unit. Notices were also displayed in the waiting room asking visitors to gel their hands before touching the patient.

The unit had a dedicated infection control lead who supported staff with the management and control of infection practices. They were also responsible for the infection control notice board. We were told this board was used to educate certain topics, during this inspection flu and the importance of vaccination and the use of standard surgical respirator masks were being highlighted.

The unit had antibiotic stewardship protocols in place. Microbiology were available when required and there were formal microbiology ward rounds three times a week. This provided advice on the use of antibiotics and the treatment of infections in the critical care unit.

Infection rates for central venous catheter (CVC) related blood stream infections were low. Data collected for 6 years, up until 2016 showed rates of 0.22/1000 CVC days. Data collection has restarted in January 2018 and there have been 0 CVC related blood stream infections

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The critical care unit was purposely designed and built in 2009 and met the guidelines for the Provision of Intensive Care Services (GPICS) 2015. The needs of patients, visitors and staff had been considered in its design.

The unit was bright and spacious throughout. There was excellent spacing between beds in the open ward areas and there were rooms available for the isolation of patients. The unit had a noise
reduction strategy and had recently installed a sound activated visual noise display meter to help monitor and reduce noise in the unit especially at night.

Light levels were also considered with lights dimmed overnight and natural light maximised during the day to help orientate patients and maintain their day and night rhythm.

Access to the unit was secure. Between 0800 – 1800 Monday – Friday entry to the unit was via a manned reception desk. Outside of these times the main doors to the unit were operated by a key pad and visitors would buzz through to the clinical staff on the unit to gain access.

There was a large pleasant waiting room for visitors, with appropriate chairs and a tropical fish tank to help make the area calm and tranquil. There were toys for children to play with, vending machines where visitors could pay for snacks and hot/cold drinks, toilets with accessible access and a television. There was no water cooler in the waiting area but reception staff told us they could provide water on request.

Reception had an emergency screen drop they could activate if needed and CCTV was installed in the waiting areas with viewing screens in reception and at the nurse’s station within the unit.

Corridors were wide and where equipment was parked i.e. the cleaners cart and visitors drink trolley, it could be done so without causing hazard or obstruction.

Thought had gone into the design of the unit to include staff facilities; there was a spacious break room, overnight accommodation for on-call staff and excellent education and training facilities.

There was a large equipment store room with key pad access.

The critical care unit had a dedicated equipment team which was consultant lead that was responsible for equipment used in the unit.

The unit had an ample supply of the equipment required to meet patient care needs. On visual inspection, medical equipment, including mechanical ventilators and renal replacement machines, were clean, serviceable and when not in use stored correctly. They were all in date for electrical safety testing.

Equipment for bariatric patients would be supplied by an external company if required. Staff told us it was a good service and equipment arrived in a timely matter. During the inspection there was need for a bariatric bed, it was delivered in plenty of time for the patient.

We observed staff using appropriate clinical and general waste bags and single use items were disposed of appropriately in either clinical waste or sharp bins.

Resuscitation equipment, including equipment for the management of airway was available on each side of the unit. We saw that this equipment was checked daily and the records reviewed did not have any gaps which showed a consistent and regular approach to safety checks.

The paediatric resuscitation equipment was located in the dedicated paediatric room. It did not lock or contain any anti-tamper tags. This trolley was checked once a week if no child was using the room. This was unsafe practice as although paediatric patients were not always on the unit, there could be children on the unit who had come to visit loved ones. This meant that the paediatric equipment could be needed at any time but staff could not be assured that equipment was still in situ.

Consumables were located in a dedicated storage room accessed by a keypad. The trust's material management team were responsible for the ordering and storage of items. They had designed a colour coded traffic light system, green, amber, red which denoted how readily
available and specialised the item was, green items could be found throughout the trust whereas red items were unique to the critical care unit.

A specialised sliding shelving system was being used in the store room which helped maximise storage space.

The unit also had dedicated transfer equipment that was taken to the emergency department and general wards when critical care staff needed to treat or retrieve patients from those areas. This meant patients in all areas of the hospital had access to critical care equipment and could be transferred in a safe and effective manner.

The critical care unit had a newsletter titled ‘The Kit Bag’ which talked about equipment used in the unit, whether this be about new equipment or shared problems and solutions relating to the equipment used.

Staff we spoke with told us there was sufficient equipment and consumables, including moving and handling equipment in the unit.

**Assessing and responding to patient risk**

There was a proactive approach to anticipating and managing risks to patients that used the service. Practices were embedded and staff understood their responsibilities.

Staff followed national guidance, assessed and documented patient risk on admission and 24 hours later using evidence based tools. This included the malnutrition universal screening tool (MUST), venous thromboembolism (VTE) and Purpose T assessment. The unit had a sophisticated computer information system that prompted staff to fill out information on admission and followed up every four hours to make sure all admission data was captured, this also included patient’s mental capacity. During the inspection we saw this in operation.

The unit had daily safety briefings which highlighted potential risks to patients. Since our last inspection in 2015, as well as the morning safety briefing at 10:25, the unit had introduced a 22:30 evening safety briefing.

We observed three safety briefings during the inspection. These were multidisciplinary meetings where safety issues on the unit were discussed so all team members were aware of them. The meetings were attended by a mix of staff on duty but had to include all doctors, the nurse in charge for each side of the unit and the advance critical care practitioners (ACCP). There was a set agenda which included ‘patient specific risks’ for example high risk infusions, allergies, potential airway problem, tracheostomies, infection control issues and contingency plans; ‘capacity; staffing and logistics’ for example capacity in the unit, identification of airway trained doctors and staffing levels; and ‘critical incidents, near misses and positive learning events’ for example the previous days cardiopulmonary resuscitation was discussed, what had gone well, what could be improved and the emotional impact on the team.

The safety briefing took no longer than 10 minutes and for staff who were not able to attend the information was cascaded to them via their shift leaders.

We observed effective nurse handovers and shift changes during the inspection. There was an initial handover from the nurse in charge of the previous shifts to all nursing staff working on the next shift. This ensured all staff had an overarching review on the status of all patients. Information discussed included patient allergies, how fed, medications, how ventilated, deterioration status and if there were any social issues/concerns, including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and The Deprivation of Liberty Safeguards (DoLs) details. From this
handover nurses would enter the unit and take a detailed handover about their allocated patient(s) from the nurse on the previous shift. All aspects of their care and treatment were discussed and potential patient risks highlighted.

The unit had recently introduced a new zone system and zone leaders. This meant that each side of the unit was split into two teams with a team leader in each. Each team had a brief team meeting, no longer than five minutes, at 07:50, 12:50 and 20:50. The team introduced themselves and made each other aware of any pertinent patient safety issues or activities, i.e. resuscitation status, difficult airways, CT or theatre trips and establishing IV competence amongst the team. The zone leader had to be an experienced band 5 nurse with the post ITU course qualification and was responsible for co-ordinating breaks at appropriate times, supporting junior colleagues and co-ordinating care within the zone. During the inspection, we saw this system in operation and it was an effective way to manage each area.

There was a critical care outreach team that operated 24 hours a day seven days a week. The team consisted of nurses who had extensive skills and knowledge in recognising and treating deteriorating patients.

General wards could refer acutely ill and deteriorating patients to the critical care outreach team. The wards used a track and trigger tool where certain criteria would trigger a referral. The critical care outreach team would aim to stabilise and improve patients at ward level to avert admission to the critical care unit. If this was not possible they would facilitate admission to the critical care unit.

The critical care outreach team were involved in the education of staff in the deteriorating patient. The team provided teaching sessions to other wards and staff, delivered formal teaching on the trust’s induction program on escalation of the deteriorating patient and sepsis and were involved in the trust quality improvement initiative ‘Time to Act’ which aimed to improve care of the deteriorating patient.

The critical care outreach team provided a tracheostomy support service which supported the general wards to care for patients with tracheostomies. Every patient in the hospital with a tracheostomy was followed up by the critical care outreach team.

We were told by medical staff that ventilated patients were never looked after on a general ward. The only circumstances when patients would be ventilated outside of the critical care unit were if patients were being stabilised before admission to the critical care unit or on rare occasions, the theatre team would continue to look after a ventilated post-operative and stable level 3 patient whilst a bed was being made available on the critical care unit.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide right care and treatment.

The trust has reported their staffing numbers below for nursing and midwifery staff from April 2017 to March 2018.

Fill rates ranged between 84.7% to 92.1% during the period. As of March 2018 there were 15.5 fewer WTE staff in post than the trust planned to provide safe and effective care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>127.0</td>
<td>116.9</td>
<td>92.1%</td>
</tr>
<tr>
<td>May</td>
<td>128.0</td>
<td>117.0</td>
<td>91.4%</td>
</tr>
<tr>
<td>Month</td>
<td>P16 Total Numbers (Planned vs Actual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>134.4</td>
<td>116.4</td>
<td>86.6%</td>
</tr>
<tr>
<td>July</td>
<td>134.4</td>
<td>114.5</td>
<td>85.2%</td>
</tr>
<tr>
<td>August</td>
<td>134.4</td>
<td>113.9</td>
<td>84.7%</td>
</tr>
<tr>
<td>September</td>
<td>133.4</td>
<td>113.2</td>
<td>84.8%</td>
</tr>
<tr>
<td>October</td>
<td>133.4</td>
<td>117.1</td>
<td>87.8%</td>
</tr>
<tr>
<td>November</td>
<td>134.0</td>
<td>119.0</td>
<td>88.8%</td>
</tr>
<tr>
<td>December</td>
<td>134.0</td>
<td>116.8</td>
<td>87.2%</td>
</tr>
<tr>
<td>January</td>
<td>134.0</td>
<td>117.2</td>
<td>87.4%</td>
</tr>
<tr>
<td>February</td>
<td>134.0</td>
<td>118.8</td>
<td>88.7%</td>
</tr>
<tr>
<td>March</td>
<td>134.0</td>
<td>118.5</td>
<td>88.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From January 2017 to December 2017, the trust reported a vacancy rate of 8.1% for nursing staff in critical care. The trust did not have a target vacancy rate, but nursing midwifery staff had a higher vacancy rate than the trust total for all staff groups of 7.3%.

(Source: Updated data supplied by trust post inspection)

As at December 2017, the trust reported a turnover rate of 8.7% in critical care which is better than the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, the trust reported a sickness rate of 2.6% in critical care. This is better than the trust target of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Between January 2017 and December 2017, the trust reported bank and agency usage in terms of shifts filled by bank or agency staff and shifts unfilled. They have not provided the total number of shifts available which means we could not provide a percentage usage rate.

<table>
<thead>
<tr>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>401</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The unit funded to have 19 nurses plus two supernumerary nurses (a nurse in charge and a deputy nurse in charge) on each shift. This meant the unit was funded to take up to 19 level 3 patients or a mixture of level 3 and 2 patients.

The unit fully met nurse staffing standards as recommended in the guidelines for the provision of intensive services (GPICS).

Nurse staffing levels followed national guidance, 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. There was also a healthcare support worker rota’d on each shift.

There was an identified lead nurse, the matron of the critical care unit, who had overall responsibility for the nursing elements of the service.

The unit had a nurse in charge and a deputy nurse in charge of every shift. They were supernumerary and looked after one side of the unit each.
There was a dedicated training team headed up by a practice educator. They were responsible for coordinating the education and training for the critical care nursing team.

All nursing staff appointed to the critical care unit were allocated a supernumerary period. This was six weeks for nurses that had not worked in the critical care environment previously and four weeks if they had.

There were 80% of the nursing staff with a post qualification award in critical care nursing. This made the GPICS standard that ‘a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing’. This meant that patients were cared for by nurses who had the appropriate skills and qualifications.

We were told staff retention was good. However with a stable senior workforce, the junior nursing staff said it did lead to a lack of promotion and career progression. The unit was addressing this by offering rotation roles in areas such as the critical care outreach team, the follow up clinic team, the unit’s dedicated IT group and the teaching team. The idea being that staff could gain more experience in different areas which would help with their career and personal development. These rotation roles were using a percentage of their time, meaning they still worked some hours clinically in the critical care unit. Staff we talked with spoke highly of these opportunities and enjoyed the challenges of learning different skills in other areas.

Agency staff were not used on the unit although bank nursing staff were. These staff were usually already known to the critical care unit. In addition at busy times, when more nurses were needed due to complex patients or times of staff shortage, the unit could call on the support of the nurses in the rotation roles therefore giving the unit flexibility at times of staffing pressure. Night staffing levels were set higher to reflect the fact that these additional nursing staff were not available to be called if needed.

The unit also employed three research nurses with 50% of their time being clinical ward based and military nurses.

**Medical staffing**

The service had taken action to ensure there was enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide right care and treatment.

The trust has reported their staffing numbers below for medical and dental staff from April 2017 to March 2018.

Fill rates ranged between 89.4% to 102.8% during the period. As of March 2018 there were similar whole time equivalent WTE staff in post than the trust planned to provide safe and effective care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>35.9</td>
<td>36.9</td>
<td>102.8%</td>
</tr>
<tr>
<td>May</td>
<td>36.9</td>
<td>36.0</td>
<td>97.6%</td>
</tr>
<tr>
<td>June</td>
<td>36.9</td>
<td>34.0</td>
<td>92.1%</td>
</tr>
<tr>
<td>July</td>
<td>36.9</td>
<td>33.0</td>
<td>89.4%</td>
</tr>
<tr>
<td>August</td>
<td>36.9</td>
<td>36.8</td>
<td>99.6%</td>
</tr>
<tr>
<td>September</td>
<td>36.9</td>
<td>36.8</td>
<td>99.6%</td>
</tr>
<tr>
<td>October</td>
<td>36.9</td>
<td>36.8</td>
<td>99.6%</td>
</tr>
</tbody>
</table>
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From January 2017 to December 2017, the trust reported a vacancy rate of 1.8% for medical staff in critical care. The trust did not have a target vacancy rate, but medical staff had a lower vacancy rate than the trust total for all staff groups of 7.3%.

(Source: Updated data supplied by trust post inspection)

As at December 2017, the trust reported a turnover rate of 0.0% in critical care. This is below the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, the trust reported a sickness rate of 0.0% in critical care which is below the trust target of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

Between January 2017 and December 2017, the trust reported bank and agency usage in terms of shifts filled by bank or agency staff and shifts unfilled. They have not provided the total number of shifts available which means we could not provide a percentage usage rate.

<table>
<thead>
<tr>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

The unit had 15 critical care consultants who provided a 24 hour 365 days a year service. During the day there were two consultants on duty for clinical duties and at night one consultant for clinical duties. This meant if all beds were occupied there was a ratio of one consultant to 12 patients in the day and one consultant to 24 patients at night. This meant that although the unit met the GPICS standards of a consultant/patient ratio of between 1:8 – 1:15 in the daytime, it did not meet this standard at night.

The unit had a minimum of four junior doctors working on each shift day and night. This meant the unit met the GPICS standards for trainee/junior medical staff to patient ratio.

We were told by senior staff that there was a shortage of middle grade medical staff. This problem is not specific to the critical care unit at Queen Alexandra hospital but is a national concern.

Consultant staff covered vacant middle grade roles by working shifts as registrars. Consultants we spoke with said this was not ideal but understand it needed to be done to ensure patient safety. Patient’s records clearly detailed whether the consultant was working in their consultant or registrar role.

To help with the shortage of junior doctors in the critical care unit, the role of advanced critical care practitioner (ACCP) had been developed. The critical care unit at Queen Alexandra hospital in
collaboration with the University of Southampton had developed a two year course. The unit currently had eight ACCP trainees working and training in the unit. Five were in their second year and would qualify in August 2018 and three in their first year. This ACCP role was seen as a way to safely fulfil a proportion of the roles currently only undertaken by medically qualified intensive care doctors.

We spoke with several of the ACCP trainees, the education team and the consultants about this new role. It was universally accepted that the role would be a good addition to the workforce but there had been a steep learning curve in how this role should develop and how much responsibility the trainee should be given and when. The ACCP trainees we spoke with said the role was challenging and demanding due to working patterns and the amount of studying involved. We had mixed reviews from the ACCP trainees with some saying clinical supervision and support was good and others feeling that responsibility had come too quickly. It seemed unclear when we spoke to staff in the unit if the role was supernumerary.

**Records**

Staff kept detailed records of patients care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Staff used an effective and sophisticated computer information system (CIS). Each of the 24 bed spaces had a designated computer terminal that was locked to it where patient’s records were entered into. The majority of medical equipment used to support and treat the patient such as the ventilator, monitors, infusion pumps and analysers were connected to the computer. This meant there was a continuous recording of patient observations and well-being. Staff could easily identify trends in their patient’s conditions and there was no risk of measurements of observations being wrongly recorded.

Currently the some IV pumps and the enteral pumps were not integrated into the CIS and information had to be manually entered. However we were told by the IT team that plans were in place to migrate this data into the system as soon as possible.

As well as a computer at the bedside, there were additional terminals at the central nurse’s station and in quiet rooms located off the main critical care unit. The unit also had two computers on wheels (COW machines). This meant staff could access patient’s records and monitor trends in their well-being when not at the patient’s bedside. The COW machines were portable and used on ward rounds.

All staff working in the critical care unit had personal log in details for the CIS. This meant when information was entered onto the system it was dated, timed and the name of the person entering the information was recorded. Throughout the inspection we observed staff using their own login details on the CIS and not entering information under other staff logins.

If non-critical care staff i.e. doctors from other specialties needed to enter information on the computer system the data would be entered under the nurse at the bedside login details and a note put in to say who had actually entered the data. This meant access to the system was limited and controlled but it gave the freedom for other non-critical care staff to add their notes to the patient’s records.

The unit had a dedicated IT team that maintained and updated the CIS. To make sure the system was fit for purpose a team of nursing and medical staff worked with the IT team to assist in the development and upgrades to the system. All staff were encouraged to suggest changes that
would make the system fit the needs of patients and make the recording of information more effective.

All medical, nursing and allied health professional’s notes were recorded onto the CIS. There were clear prompts for the various teams to make sure vital data was not omitted. We were shown the prompts used to admit patients, to complete assessments and to develop care plans including sepsis prompts and a recent system update that prompted staff to include mental health assessments. The system prompts by default every 4hrs but this could be adjusted to meet the needs of the individual patient.

Patients allergies were clearly identified on the system and all patient’s lines, drains etc. were detailed on a body map as well as any wounds, injuries or bruises. We observed staff adding cannula information on to the body map and checking the body map to see if a bruise was new.

The system not only captured physiological measures but also information on patients DNACPR status, next of kin and relative information and the psychosocial aspects of patients.

New staff were given comprehensive training on the system. Staff we spoke with told us the system was quick and easy to use and was integral to the care and safety of patients being looked after on the unit.

To mitigate against computer problems the unit had trained certain members of staff at all grades to be super-users. Super-users had more in depth knowledge of the system and could trouble shoot and offer advice and help to others. There were enough super-users trained to try and have one on every shift, although due to the complexity of staffing this was not always the case. In addition to the super-users IT staff were on call 24 hours a day seven days a week if there were more technical issues with the system.

There were processes and back up plans in place should the CIS fail. Paper records were available in the event of such failure. This made sure data was not lost and patient’s treatment and safety was not compromised.

The CIS was only used in the critical care unit; however, the unit had developed, in collaboration with the general ward staff, a discharge summary report. Information required by the wards for smooth and safe transfer of patients was automatically downloaded from the CIS onto a discharge summary proforma. This was then printed off onto purple paper and given to the ward. The CIS would only allow the proforma to be printed off once it had been checked and approved by senior critical care nursing and medical staff. This was a well-developed and robust system.

During the inspection we observed staff using the CIS effectively and we checked six sets of records. We found the system to be impressive and patient records were comprehensive, detailed and up to date.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

There was a dedicated lead pharmacist for the critical care unit who attended ward rounds five days a week. The post was 0.7 whole time equivalent (WTE) at band 8a level. However, this did not meet the GPICS standards of having 0.1 WTE band 8a pharmacist for every level 3 bed. There was no weekend critical care cover. There was on call pharmacy support out of hours and at the weekend. Pharmacists checked patient’s prescriptions, provided guidance and support about prescriptions and the administration of medicines, including the prescribing of antibiotics.
We reviewed medicine prescriptions drug administration charts on the computer information system. This showed nursing staff administered the prescribed dose of medicines at the time they were prescribed for. Nursing staff said they received training about the safe administration of medicines, including injectable drugs and IV training. Nursing staff could only administer medicines after they had completed competency assessments. We saw evidence of completed training records.

Medicines were stored in secure areas, with access gained via a key pad Controlled drugs (CD) were stored in a locked cupboard inside the secure area with keys kept by the nurse in charge. During the inspection a spot check of the stored medication, CD stock and record book was carried out and demonstrated compliance with relevant legislation.

Medicine fridges were kept within the correct temperature range, which was checked daily and records we saw confirmed this. When we asked what would happen if fridges went out of range we were told by clinical staff that they would contact the lead pharmacist or the pharmacy department for advice. The unit also had fridges that were used for research medication. These fridges did have the correct forms for checking the temperatures and records were not up-to-date or accurate.

Staff told us about processes that were in place to identify stock nearing end of life and how it would be redistributed within the hospital, which had a cost benefit to the hospital.

Emergency grab bags were stored securely in unlocked fridge in the medicine store cupboard, these were checked daily and audited in the safety briefing. Grab bags were tagged to show they had not been tampered with.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported no incidents classified as never events for critical care.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from January 2017 to December 2017.

*(Source: Strategic Executive Information System (STEIS))*

All staff we spoke with in the critical care unit knew how to escalate and report incidents. Staff explained that incidents were reported using an electronic reporting system. They all understood their responsibility to raise concerns and felt confident to report them. Staff told us there was a no blame culture attached to the occurrence and reporting of incidents.

A list of adverse incidents reminders was displayed for staff to see, which listed the types of incidents that should be reported. It also reminded staff to record the incident in the patient’s notes and to inform the patient and/or their family.
The service used many ways to ensure staff received feedback about incidents. Information was emailed to staff and spoken about in meetings and handovers.

The innovative use of ‘watch out’ electronic screens on the unit displayed details about incidents, it explained what happened, the facts and how to protect patients and to prevent the incident reoccurring. These screens were placed in areas where staff stood for a few minutes i.e. where staff gathered for the safety briefing or by the blood analysis machine, increasing the likelihood that staff would read information displayed on the screens.

The twice daily safety briefing included discussions on incidents and near misses and the action and learning taken in response to these incidents.

There was an incident notice board in the staff room. Information was displayed on how to report an incident and recent incidents that had occurred and the action taken. The board was split into area, high harm, moderate harm, low harm and no harm incidents and incidents place the relevant category. This gave a quick visual indicator of the types of incidents occurring within the unit.

We looked at the recording of incident data from Apr 2017 to Mar 2018. During this period there were 20 near misses and 251 incidents resulting in no harm. There were 100 incidents that resulted in low harm (this means minimal harm that required extra observation or minor treatment) and 8 incidents that resulted in moderate harm (this meant short term harm that required further treatment or procedure).

We saw evidence that the unit held monthly mortality and morbidity meetings. Mortality and morbidity meetings are peer reviews of the care of patients with the object to learn from complications and errors and to prevent repetition of any errors leading to complications. We found there was a multidisciplinary approach to these meetings and anyone from the critical care unit was welcome to attend.

Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Staff we spoke with knew about the process and stressed that there was an embedded culture in the critical care unit to be open, honest and transparent with patients and their relatives.

**Safety thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the critical care unit reported two new pressure ulcers, no falls with harm and no new catheter urinary tract infections from December 2016 to December 2017.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Portsmouth Hospitals NHS Trust

(Source: NHS Digital)

### Is the service effective?

#### Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

There was a lead consultant and senior nurse for guidelines who would make sure all national guidance/best practice and recommendations were followed.

Clinical guidelines and policies were developed and reviewed in line with National Institute for Health and Care Excellence (NICE), the Royal College, the Intensive Care Society, the Faculty of Intensive Care Medicine and other relevant bodies. Policies and protocols were available on the hospital's intranet, on the critical care unit’s computer information system and on the hospital’s internet.

In line with national guidance and best practice, patients had a rehabilitation assessment completed within 24hrs of admission to the unit.

In line with NICE guidance (CG83) patients discharged from the critical care service had access to follow up clinics and services.

Queen Alexandra’s critical care staff were involved in producing national guidelines for refractory hypoxemia.

Staff followed nationally recognised care bundles. Care bundles consist of a group of three to five evidence based interventions for patients in critical care. These included care bundles to reduce the risk of ventilator-acquired infections. These were all compatible with national standards practice and guidance.

There was a lead consultant for audits. The critical care unit took part in a number of national audits to measure the effectiveness of the care and treatment provided. This included the Intensive Care National Audit and Research Centre (ICNARC) unit. The unit also had an internal audit programme. This was reviewed annually by the unit’s lead consultant for audits. Audit findings were used to improve practices and the quality of patient care received in the unit.

#### Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
There is evidence that nutritional care is better provided and superior patient outcome achieved, if a critical care dietitian is involved in the multidisciplinary team. Since our last inspection in 2015, the critical care unit had employed a dedicated dietitian. This met with the GPICS guidelines that ‘there must be a dietitian as part of the critical care multidisciplinary team’. The dietitian was present on the unit during this inspection. They were involved on ward rounds and safety briefings and gave advice and support to the critical care team.

All patients on admission to the unit and prompted by the computer information system, had their nutritional and hydration needs assessed. Their risk of malnutrition was assessed using a national validated nutritional screening tool, the Malnutrition Universal Screening Tool (MUST). When we reviewed patient’s records, they showed that staff monitored and documented patient’s nutritional and fluid intake and reviewed their MUST scores at the correct times.

Staff followed protocols and policies regarding enteral and parenteral feeding practice.

A speech and language therapist (SLT) was available to support patients with tracheostomy and those with swallowing difficulties. The SLT provided instruction to staff on how to support patients with swallowing difficulties with eating and drinking. There is no nationally agreed guidance about the minimum SLT staffing levels in the critical care environment. There was no dedicated SLT attached to the Queen Alexandra critical care unit, however, staff we spoke with felt the present SLT provision supported them to provide safe and effective care to patients. During the inspection we regularly saw members of the SL team on the unit assessing patients’ needs and supporting critical care staff.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. Patient’s pain was well managed. Staff monitored patient’s pain and response to pain as part of routine observations. In addition, the CIS prompted nursing staff to assess patient’s pain levels. Staff demonstrated a good understanding about identifying patient’s pain.

Patient’s pain was monitored following the critical care’s sedation and delirium policy, which gave guidance on the management of pain, agitation and delirium.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used findings to improve them. They compared local results with those of other services to learn from them.

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The unit had dedicated staff who ensured data was regularly fed into the ICNARC network.

Data was used from the 2016/17 Annual Report.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

For the intensive care unit at Queen Alexandra Hospital, the risk adjusted hospital mortality ratio was 1 for 2016-2017. This was within the expected limits and the same as the average for England, Wales and Northern Ireland. The figure in the 2015/16 annual report was 1.1.

*(Source: Intensive Care National Audit Research Centre (ICNARC))"
For the intensive care unit at Queen Alexandra Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.7. This was within the expected levels. The figure in the 2015/16 annual report was 1.

(Source: Intensive Care National Audit Research Centre (ICNARC))

We saw evidence that ICNARC reports were disseminated to critical care staff. Data was explained and areas where the unit could improve were highlighted.

The critical care unit had an annual audit programme to monitor patient outcomes and improve the service.

The critical care unit followed the national guidance in identifying a patient’s potential for organ donation. Staff, in consultation with the specialist nurse for organ donation (SNOD), would approach patient’s relatives to discuss this delicate area. The department’s data demonstrated an improvement each year in organ donation and was better than the national average, with 100% for brain stem death and 84% for circulatory death.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From April 2017 to March 2018, 88% of staff within critical care at the trust had received an appraisal which was better than the trust target of 85%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>35</td>
<td>34</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>138</td>
<td>119</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>189</strong></td>
<td><strong>167</strong></td>
<td><strong>88%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

All staff groups except support to doctors and nursing staff met the 85% appraisal target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

All staff at every level were observed to be skilled and competent in their role.

Training and educational development was embedded in the critical care unit. The unit had an education team headed up by the education lead. The education lead was responsible for the education needs of the Critical Care, Hospital Sterilisation and Disinfection Unit, Dept. of Anaesthesia and Theatres (CHAT) clinical service centre.

Members of the educational team maintained their working time in clinical practice in addition to their education role to ensure they remained current with clinical skills. Band 5 & 6 nurses rotated into the team from the critical care unit their time was split 50:50 between the educational team and working in the unit.
The critical care unit had a structured development programme for all staff that included unit and role specific induction programmes, competency frameworks and career development matrixes. Nurses new to the critical care nursing received six weeks of supernumerary shifts in order to learn essential skills to care for level 2 and 3 patients safely. Nursing staff that had previously worked in the critical care environment had four weeks of supernumerary shifts. Until staff had completed these periods they would be encouraged to work the shorter shift patterns.

There was a strong emphasis on mentoring staff. Nurses new to the unit would be allocated two registered nurse mentors and be part of a senior sister’s link team. During the inspection we saw mentors helping staff and staff filling out their competency booklets.

After initial critical care competencies had been completed the unit ran a ‘nuts and bolts’ training programme for staff which included more specialised training in areas such as spinal, renal and cardiac critical care and also included simulation (SIM) training.

The unit supported ten nurses per year to apply and complete post registration qualifications in critical care nursing. At the time of our inspection 80% of staff had a post registration qualification in critical care nursing which met the GPICS recommendation of a minimum of 50%.

Nursing staff were encouraged to apply for rotation posts, where they could learn additional skills and continue their professional development. Staff would spend a fixed period of time working alongside a specialist team. This included roles in research, outreach, IT, retrieval team, educational team and follow up clinic. Staff we spoke with about rotation posts all said it was good to gain further knowledge and learn different skills.

One qualified intensive care nurse was seconded to undertake a course in paediatric nursing. This was to ensure there was sufficient numbers of paediatric nurses to care for children admitted to the unit. We spoke with nurses who had completed this course.

The critical care unit worked with local universities to employ student nurse placements and saw this as a way to help recruit future nurses. Student nurses were always supernumerary and mentored whilst gaining practical experience in the critical care environment.

In response to difficulties in recruiting middle-grade doctors, the unit in partnership with Southampton University, had developed a two year course in advanced critical care practice (ACCP). The course was accredited by the Faculty of Intensive Care Medicine. The unit currently had five year two trainees and three year one trainees, who were consultant supported and mentored. Staff at all levels told us how valuable the ACCP role was becoming in the unit.

The unit was committed to providing support and training for junior and trainee medical staff with a critical care consultant managing and coordinating the training. Regular training included a weekly journal club, core curriculum training, incident and mortality review and multidisciplinary (MDT) topics presented by other specialists. The MDT session was open to all on the critical care unit, including nursing staff, ACCPs and allied healthcare professionals. Many of the staff we spoke with had attended these MDT sessions and found them inclusive and educational.

The educational team maintained a staff training notice board. When we reviewed the board there was information on that week’s daily training which included fire training, manual handling and freedom to speak up guardian. We also saw the training schedule for the upcoming months. We saw that training was available to all members of critical care staff, including the ministry of defence staff working on the unit, and on an array of topics.
**Multidisciplinary working**

Staff of all grades and all disciplines worked together as a team to benefit patients. Doctors, nurses, healthcare professionals and administration staff supported each other to provide excellent care.

We saw many examples of MDT working including the daily safety briefing, ward rounds which included input from the pharmacist, dietitian, physiotherapist and microbiologist, as well as medical nursing staff.

Dedicated IT and technical staff supported staff with the management of IT systems and equipment.

There was a dedicated physiotherapist lead for the critical care unit who with a team of physiotherapists, worked collaboratively with the nursing and medical staff to ensure that patients received the support they required. During the inspection we saw this happening.

Since the last inspection the critical care unit had employed a dedicated dietician, who we observed interacting with other members of the critical care team during this inspection.

The unit worked closely with the specialist nurses for organ donation (SNOD). The SNODs supported families in the critical care unit in making informed choice on organ donation, depending on their loved ones wishes and then facilitating the process of donation.

The critical care outreach team worked across the whole trust, supporting ward staff in the care of patients who had recently been discharged from critical care or who were or were likely to become critically ill. They also facilitated learning and good practice in regards to the deteriorating patient for staff across the trust.

The critical care unit had a dedicated pharmacist.

Other professionals visited the unit as necessary, for example the speech and language therapists and members from the bereavement team.

All staff we spoke with told us there was a collaborative and supporting way of working in the critical care unit and everyone had their part to play and this was extremely evident during the inspection.

At present although the psychological needs of patients were addressed by the critical care staff there was no dedicated psychologist attached to the unit.

**Seven-day services**

Seven day services were not fully established across all of the multidisciplinary teams, although services did meet the requirements for the GPICS seven day standards.

The service had intensivist cover on site 24 hours a day, seven days a week.

A physiotherapy service was available 24hrs a day, with a dedicated physiotherapist available 0700 – 1930 Monday to Friday and 0800 – 1600 on weekends and bank holidays. Outside these hours there was an on-call service.

A dedicated pharmacist was available week days which met the minimum GPICS standard. However, GPICS recommends that pharmacy services ‘must ideally be available seven days a week’. Critical care staff were able to access trust wide pharmacy services at weekends as needed.
The specialist nurses for organ donation (SNOD) offered 24 hours a day, seven days a week service.

There was access to other services seven days a week, for example the unit had its own blood analyser, where basic blood samples could be processed however for other needs the trust had an onsite pathology team which was available seven days a week, with out-of-hours being an on-call service. Radiology and radiography services were available during core working hours with an on-call service out of hours for urgent requests.

Since our last inspection in 2015, the critical care outreach team now provided a seven day a week, 24hr a day service.

Health promotion

Patients and relatives we spoke with told us they were involved in their care. They felt information was explained by staff in ways they could understand. They felt they were involved and supported in the decision making process of their care and treatment.

We saw a range of health promoting literature and posters displayed in waiting areas and corridors leading to the unit.

The critical care unit’s follow up team supported patients and their relatives following discharge from the unit. Part of this support included health promotion, supporting patients and their relatives to understand their critical illness and their recovery stages. As part of this service patients were signposted to organisations that could support them to manage their own health and wellbeing or where required, the team made referrals to appropriate health care professionals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their cases. They followed the trust policy and procedures when a patient could not give consent.

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty training.

A breakdown of compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) courses from April 2017 to January 2018 for medical and dental staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>35</td>
<td>35</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>35</td>
<td>35</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>17</td>
<td>20</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff met the trust training target for DoLS intro and MCA Levels 1 and 2 but not for the DoLS enhanced module

A breakdown of compliance for MCA and DoLS courses from April 2017 to January 2018 for
nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>138</td>
<td>143</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>138</td>
<td>143</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>117</td>
<td>136</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>116</td>
<td>136</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff met the trust training target for all MCA and DoLS modules.  
(Source: Trust Provider Information Request)

Data supplied was from April 2017 – Jan 2018 therefore there were still several months of the financial year for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) courses to be completed.

Conversations with staff indicated they had a good understanding of their responsibilities towards the mental capacity (MCA) act and deprivation of liberty safeguards (DoLS). The critical care unit had a lead senior nurse for MCA and DoLS who could offer advice and support to staff. All staff we spoke with knew who their lead for MCA and DoLS was and felt confident in seeking their input.

The unit lead for MCA and DoLS told us how they carried out yearly audits to address if staff were following policies into MCA and DoLS correctly. Additional training sessions would be arranged depending on the results of the audits.

The critical care unit’s computer information system prompted medical staff to complete mental capacity assessments when patients were admitted. Since the last inspection in 2015 the CIS had been updated and now if a patient had been identified as having mental health issues the CIS would issue further prompts to make sure continuous mental health concerns were addressed. We saw patient records had been filled out correctly and the records we reviewed showed that MCA and DoLS had been completed appropriately.

The trust had a protocol to follow in the event of applying for DoLS authorisations. We saw posters throughout the critical care unit explaining the process and where to go for further advice. We also saw posters relating to making decisions in regards to best interests, assessing capacity, advanced treatment and when an independent mental capacity advocate would be required.

The critical care unit had a policy for when to use restraint in the critical care environment. Staff we spoke with could tell us about this practice and we saw posters throughout the unit, explaining restraint, when to use it and how it should be documented.

**Is the service caring?**

**Compassionate care**

Staff were committed to providing compassionate care for patients and their families. During the inspection, we saw staff treated patients and their families with compassion, dignity and respect.
Staff were passionate about the care they provided. Staff were aware of the importance of providing compassionate care and the impact on the patient and their families.

There were many examples of how staff went above and beyond what was considered normal practice to demonstrate care and compassion. Patients and their loved ones demonstrated their gratitude in many forms.

- The unit had received numerous thank you cards from patients and their families, with many being displayed in the main reception area and the staff room notice boards. We read many of the cards and comments, words regularly used to describe the critical care team were; ‘compassion’, ‘kindness’, ‘dedication’, ‘thoroughly professional’, ‘attentive’, ‘respectful’.

- We were shown a short video that had been made by a patient and their family whilst being a patient in the unit. Whilst documenting the amazing recovery he made, it also gave thanks to the staff for their physical and psychological support which included visits outside so the patient could feel the ‘wind on his face’. The family said in the video, that ‘staff were amazing and the patient could not have gotten better care’.

- We also saw a book of cartoons that a family member of a patient had made about their time in the critical care unit. This was made and given to staff, as the inscription at the start of the book says, ‘to celebrate and give thanks for the fantastic care of our mum’.

- There was a poem displayed in the waiting room that had been penned by a patient’s family to celebrate and say thanks for the care their father had been given in the unit.

The unit had recognised the importance of visitors to patients whilst they were on the unit therefore visiting hours were open (24hrs/day). Although the importance of patient rest periods was explained to relatives and explained that it improved recovery. Two visitors were allowed at a time. This was relaxed if circumstances required, especially if patients were nearing end of life, and we saw evidence of this during the inspection.

Compassionate care was embedded in all staff working in the critical care unit and everyone we spoke with and from our observations confirmed this. For example, we saw patients being comforted and cared for by staff on the unit and visitors afforded equal consideration. We observed unconscious/sedated patients being communicated with by nursing and medical staff in a compassionate way. All staff introduced themselves by name, told the patient they were safe and explained what was happening to them. It was the norm in the unit for nurses to wash their patient’s hair and moisturise their skin. We were told by the cleaning staff that if a patient had no family or other visitors, if the circumstances were appropriate, they would spent a little extra time with that patient.

From our observations it was clear that protecting patient’s privacy and dignity was second nature to staff caring for patients. Staff instinctively closed curtains around bed spaces for personal interventions or delicate conversations regardless of the conscious state of the patient. Equally curtains were reopened to promote inclusion for the patient.

**Emotional support**

Staff provided emotional support to patients and their families to minimise their distress.

The unit promoted the use of patient’s diaries. These are an ongoing record of a patient’s stay in critical care, written for the patient. It is a daily record of what happened to them during their stay, including showing how their condition changed, who came to visit them and what was going on in
the outside world whilst they were in the unit. Evidence suggests that helping the patient understand what happened to them whilst in critical care can aid their psychological recovery by filling the memory gaps.

The unit offered follow up clinics to all patients who had a stay of more than three days in the critical care unit. Patients could have multi-faceted problems related to a stay in the critical care unit, including both physical and psychological problems. The follow up clinic followed up patients by inviting them to an outpatient appointment at intervals after their discharge from hospital. This provided patients with the opportunity to discuss any issues they or their family had. The team would also signpost patients to relevant support groups, or referred patients to appropriate health care professionals. The critical care unit had a notice board in the unit explaining the problems that could be faced by patients after a period in critical care. It also showed results of a follow up clinic audit that was carried out, showing that 99% of patients who completed the survey thought the clinic had benefited them in some way.

Staff told us they stayed in touch with patients after discharge from the unit and that some were still regular visitors to the unit, offering their support to current patients and their relatives.

The trust’s chaplaincy team were available, 24 hours a day, 7 days a week to provide spiritual, religious or pastoral support to patients, visitors and staff of all, any or no faiths. There was a chapel and prayer room and a multi-faith prayer room in the hospital. Information boards on the unit contained details of how to contact the spiritual healthcare specialists.

The hospital had a Bereavement and Palliative Care Team that supported families and friends of patients on the critical care unit. They offered sensitive practical advice and emotional support for bereaved family and friends.

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

Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

We observed staff explaining to patients and their relatives the care and treatment that was being provided. Medical ward rounds were conducted not just in front of patients and relatives but involving them, making all information and decisions transparent and inclusive.

Staff recorded details of conversations on the electronic recording system. This meant that staff always knew what explanations had been provided and reduced the risk of confusing or conflicting information being given to relatives of patients.

Relatives we spoke with and feedback from patient and relative’s cards, showed us that staff on the unit were supportive and explained procedures, equipment, terminology and treatment thoroughly.

Staff followed processes to contact the specialist nurse for organ donation (SNOD) to speak sensitively to relatives of patients about organ donation when treatment was being withdrawn. The SNOD had specialist training to equip them with the necessary skills to speak about this subject and help relatives understand the choices they had and the processes for organ donation.

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**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.
The unit took account of the needs of the local population. Service leads understood the need for a flexible service which could flex and adapt to the fluctuating demand for critical beds. For example, staff took on different roles in the critical care unit (outreach team, follow up clinics, IT team) but also continued to work some clinical hours in the unit. This meant at times of severe pressure there were staff with the required skills to call upon to continue to be able to deliver a quality service.

The unit had been designed with both patients and relatives in mind. Reception was manned Monday to Friday 8am to 7pm, the waiting room was large and airy with good facilities; comfortable seating, a fish tank, television, refreshments, there were two separate rooms available for relatives to wait before entering the unit where families could be separated if needed. One of these rooms had a sofa bed if relatives needed to stay overnight. Overnight accommodation is also available offsite if required. There were quiet rooms available in the unit where sensitive information could be delivered by staff to patients and relatives.

Bed capacity of the unit meant the trust did not meet the Department of Health recommendations about the number of critical care beds needed to meet a local population. The department of health recommends 7.4 critical care bed availability per 100,000 population. The population of the local area was 675,000, meaning the critical care unit operated at 3.6 beds per 100,000 population. This did not meet the recommendation. However, at the time of building the critical care unit in 2009 the adjoining respiratory ward was built to ICU specifications as a planned expansion to the unit to increase the bed capacity if needed. Currently critical care bed capacity had not reached the point where expansion into this area needed to be considered.

To meet the needs of patients after discharge from the unit, the unit had both an outreach team and a follow up clinic. This met the Guidelines for the Provision of Intensive Care Services 2015.

The Outreach team also provided specialist advice for patients that had been discharged with a tracheostomy.

The critical care unit, with the bereavement team, could make memory boxes for patients who have passed away in critical care. The box contains special things to help remember and give comfort such as, a lock of hair or a handprint and can be further personalised if families wish.

The critical care unit were involved in a number of networks and committees to ensure they were meeting standards and to share good practice and learning across the region and beyond. For example, the Wessex Intensive Care Society.

The unit had an excellent website that could be translated into an array of languages, which provided all relevant information for patients and relatives about the critical care unit. For example, it explained what to expect when visiting the unit for the first time, all aspects of the environment, who could visit and when and details on the team working in critical care.

Meeting people’s individual needs

The service took account of patients’ individual needs.

Staff told us they treated every patient as an individual, which meant they made reasonable adjustments to meet the needs of patients with a learning disability, mental health issues or who were living with dementia, and their family members. Care plans we reviewed demonstrated that peoples’ individual needs were taken into consideration before care was delivered.
There was a good awareness amongst staff of the delirium that patients experience as a result of their treatment in the critical care environment. The unit was committed to humanising the ICU environment and took measures to control noise levels and lighting in an attempt to normalise the care environment.

We saw the recently installed ‘listening ear’. This was an electronic device that was used to facilitate noise level management. The listening ear monitored noise levels in the unit and if they exceeded a certain level, would change from green to amber to red to indicate to staff that levels needed to be addressed immediately and reduced.

The unit promoted protected sleep times and we saw the lights being dimmed for rest periods and raised for daytime hours. The unit had large windows which allowed in natural light and again we saw curtains being open and closed to indicate day and night times for the patients.

We were told by staff that interpretation facilities were accessed whether by phone or through an interpreter visiting when patients and their family members needed it. There were also many languages other than English spoken by members of the critical care team that could help in communicating with patients and relatives. There was also a flow diagram displayed by the nurses station which gave details how to meet patient interpretation needs, this included what to do for non-English speaking patients with hearing impairments, mental health issues and/or a learning disability.

During our inspection the resuscitation trolley needed to be used. After the incident the trolley was checked and restocked immediately by nursing staff. This meant it was ready to be used again if needed.

Bed positioning on most critical care units was that beds faced into the building, although some patients liked to face the windows so they could see outside. However, it had been shown that beds facing towards the window and not into the unit could leave patients feeling vulnerable and isolated if they couldn’t see where the staff were. Each bed space in the critical care unit had a ceiling mounted pendant system, which is a console where equipment including electrical, gas and monitors can be plugged in to. The pendants at the Queen Alexandra Hospital’s critical care unit were positioned half-way down the bed space rather than the usual two thirds. This meant beds could be positioned at an angle so patients could see out of the window and into the unit if they wished.

The unit took on feedback from every area (patients, relatives, regulatory bodies), to make changes and deliver a better service for patients’ individual needs. For example: taking steps to reduce noise and controlling light levels on the unit; employing a dedicated dietician; increasing physiotherapist staff on the unit; and the outreach team becoming 24/7.

The unit had recently brought in a bleep system. Relatives could leave the unit if they needed a break or if they had been asked to leave by the medical team so treatment could be given to their loved one. Carrying a bleep meant that relatives could be instantly notified when it was convenient for them to come back or if they urgently needed to return to the unit.

**Access and flow**

People could access the service when they needed it.

Admissions to the unit included elective admissions (post-operative patients), emergency admissions from all other specialties within the trust and requests and transfers into the service from other hospitals.
Since our last inspection and to help with flow and discharge from the critical care unit the team had brought in a new system. This included a more structured approach to identifying and communicating patients ready for discharge, the completion of daily capacity forms and a designated staff member being the point of call for admissions and discharges from the unit. Staff we spoke with said the system was working well and helping to reduce delayed admissions and discharges from the unit, which could be seen in the improving audit figures.

To reduce the risks for patients requiring critical care who were located elsewhere in the hospital, the unit had a specialist trained critical care team who would go retrieve the patient. Patients admitted into the Emergency Department (ED) requiring critical care were treated by the critical care retrieval team in the ED, before admission to the critical care unit. This also happened for patients requiring admission to the unit from the general wards. During the inspection we saw the retrieval team in action and were shown the dedicated equipment that was used for patient retrieval.

There was a dedicated theatre bed set up with all the necessary equipment, which was checked daily, that could be taken to theatre if needed.

Cancellation of surgery because of lack of critical care beds was 4.7%. Records showed that for the period between April 2017 and March 2018 56 surgical procedures were cancelled. We were told by senior staff that the critical care unit tried to block out three of the critical care beds for recovery post elective surgery but this number was dependent on the capacity of the unit at the time.

Some patients were discharged home directly from the critical care unit. For some patients this was assessed as being the appropriate pathway. For patients that had been inpatients for three days or more would be offered follow-up clinic appointments.

**Bed occupancy**

The Royal College of Anaesthetists recommends 70% occupancy for critical care services, in order to allow capacity for emergency admissions. The data below shows that the Queen Alexandra Hospital critical care service was mostly above the recommended 70% occupancy rate. From January 2017 to December 2017, Portsmouth Hospitals NHS Trust has seen adult bed occupancy vary between over 80% in January and December 2017 to lower than 40% in June 2017 (the trust report that the average bed occupancy for the month of June was 74%). It has generally performed in line with the England average.

**Adult critical care Bed occupancy rates, Portsmouth Hospitals NHS Trust.**

![Graph showing bed occupancy rates]

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
The Guidelines for Provision of Intensive Care Services (GPICS) 2015, details that ‘discharge from critical care to a general ward must occur within 4hrs of the decision.’ The Intensive Care National Audit Research Centre (ICNARC) reported on discharges from critical care services, of more than eight hours.

**Delayed discharges**

For the intensive care unit at Queen Alexandra Hospital, there were 6,935 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 6.3%. This did not place the unit in the worst 5% of units in England, Wales and Northern Ireland. However, it was worse than the national average of 4.9%. The critical care unit’s 2016/17 figure was similar to the 2015/16 annual report figure of 6.4%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

When we discussed delayed discharges with the senior staff on the critical care unit, they told us they would prefer patients to be delayed than to discharge them onto the wrong type of ward in the hospital, or to another ward whilst waiting for a bed to become available on the correct ward. Research had shown that this type of discharging practice was detrimental to patients’ wellbeing and recovery.

**Non-clinical transfers**

The GPICS 2015 state, ‘Patients must not be transferred to other Intensive Care Units for non-clinical reasons’. For this metric, the trust submitted 1,442 admissions to the audit. Of these 0% had a non-clinical transfer out of the unit. This was within the expected limits and better than the average for England, Wales and Northern Ireland of 0.4%. The critical care units 2016/17 figure was better than the figure in the 2016/2017 annual report of %.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Non-delayed out of hours discharges to the ward**

The GPICS 2015 details that ‘discharge from critical care must occur between 0700hrs and 2159hrs’. For the intensive care unit at Queen Alexandra Hospital, 2.6% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within the expected limits and about the same as the average for England, Wales and Northern Ireland of 2.5%. The critical care unit’s 2016/2017 figure was better than the figure in the 2015/16 annual report of 3.7%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

From January 2017 to December 2017 there was one complaint about critical care. The trust took 33 working days to investigate and close the complaint. This is just outside their complaints policy, which states complaints should be completed within 30 days.

The complaint was regarding clinical treatment.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The critical care unit proactively sought patient and relative feedback and where possible made changes in response to this feedback for example; providing relatives with pagers so they could leave the unit without worry as they could be called back immediately if needed. Everyone we spoke with during the inspection told us that transparency and honesty was embedded in the critical care unit and there was a no blame culture.
Staff we spoke with told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team as they wanted to resolve any issues before concerns escalated to become formal complaints. Complaints handling and Conflict resolution training were part of the mandatory training. If the problem could not be resolved by the team, staff told us patients would be given contact details of the Patient and Liaison Service (PALS). The PALS office had a visible presence within the main entrance of the hospital. Information regarding PALS, the services they offered and how to contact them was displayed in prominent areas in the critical care unit. We saw leaflets on PALS which patients could take away to read at home.

The critical care unit displayed ‘Help us do Better’ posters at reception, which explained and gave details of all the ways patients could make complaints, speak to the nurse in charge, through PALS or how to complain formally. There was also information on how to obtain free independent advice from the Healthwatch and details on the Independent Health Service Ombudsman.

Other posters with details on how to make comments, concerns, compliments and complaints were displayed throughout the unit.

Staff told us that feedback from complaints and concerns were discussed at the team meetings, during daily face to face catch ups and in handover sessions.

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**Is the service well-led?**

**Leadership**

There was strong leadership in the critical service, with managers having the right skills and abilities to run a service providing high-quality sustainable care.

The trust was split into 11 clinical service centres (CSC): Clinical Support; Corporate; Emergency Medicine; Head & Neck; Medicine, Medicine for Older People, Rehabilitation and Stroke; Renal and Transplantation; Surgery and Cancer; Critical Care, Hospital Sterilisation and Disinfection Unit, Dept of Anaesthesia and Theatres (CHAT); Trauma, Orthopaedics, Rheumatology and Pain; Women and Children. Each CSC had a management structure and clear lines of responsibility and accountability.

Critical care was part of the CHAT CSC. Each CSC had a chief of service, general manager, head of nursing, business manager and governance leads and were responsible for the delivery of services.

At service level and following the guidance for the provision of intensive care services (GPICS) 2015 standards the critical care unit had a designated medical lead (the clinical director of the critical care unit) and a nurse lead (the matron and operations manager of the critical care unit) to lead the clinical service. There was a nurse who led the critical care outreach service.

Each shift had a nurse in charge and a deputy nurse in charge. These roles were supernumerary and were not rostered to deliver direct patient care to a specific patient which meant they could provide leadership and support the staff on duty. This met the GPICS standards.

The unit had appointed leads for different areas in the critical care service which included areas such as, clinical governance, infection prevention, dementia, guidelines, and relative satisfaction. The leads would provide guidance and leadership to other staff about their areas of expertise.
At unit level staff told us managers were visible and were frequently in the unit. Staff spoke highly of the clinical director and the matron, consultants and senior nursing staff, saying they found them supportive and approachable. During the inspection we observed many interactions between staff and their managers and it was apparent there were excellent working relationships amongst staff.

The unit had recently introduced a new zone system and zone leaders. This meant that each side of the unit was split into two teams with a team leader in each. The zone leader was responsible for co-ordinating breaks, supporting junior colleagues and co-ordinating care within the zone. During the inspection, we saw this system in operation and it was an effective way to manage each area.

The leadership team were mindful about succession planning. The unit supported nurses who wished to complete courses that supported them with developing leadership skills. Currently the matron and operations manager of the critical care unit was acting up as the head of nursing for the CHAT clinical service centre. Whist taking on this additional duty the unit had the band 7 senior nurses, in rotation, act up one day a week to be the lead nurse for the critical care unit. This meant the matron had time for her CSC duties and the band 7 nurses developed their leadership and operational skills.

At various locations in the critical care unit there were photographs of key personnel visible to staff, patients and visitors. At the entrance to the clinical areas there was a television screen which displayed the lead consultant and lead nurse for each side of the unit for that day and night and photographs of the matron and clinical director. This meant that people could identify who staff were and make them more approachable.

Staff we spoke with were positive about the changes that had been made to the executive team. They spoke highly of the trust’s Medical Director and the new chief executive and said they were visible and approachable.

**Vision and strategy**

The critical care service had a vision for what it wanted to achieve and plans to turn it into action. The trust’s vision was ‘to be recognised as a world-class hospital, leading the field through innovative healthcare solutions, focused on the best outcome for our patients, delivered in a safe, caring and inspiring environment’.

Staff we spoke with knew how their work contributed to the vision of the trust and they were aware of the trust values of ‘respect dignity, quality of care, efficiency, working together’.

At the CHAT clinical service centre level, there were a draft business plan (FY2018-FY2023) which described the CSC’s overarching strategy for the next five years. This was further broken down into each speciality within the CSC, critical care, hospital sterilisation and disinfection unit, anaesthetics and theatres, and their individual strategy. The plan included key deliverables and the key issues/challenges to deliver these in line with local health needs and financial constraints. Monthly CSC business planning meetings reviewed progress.

At a more local level, the critical care service had a mission statement which was to provide ‘the best possible care and outcome for our critically ill patients, protect and preserve dignity through critical illness, safety and quality at the heart of everything we do, support families and loved ones, highest quality training and development for our staff. This statement was displayed at the entrance to the unit for patients, visitors and staff to see.
All staff we spoke with were committed to this mission statement and told us the unit was working together as a team to deliver excellent quality sustainable care for their patients and the local community.

**Culture**

The critical care service promoted a positive, inclusive and collaborative culture that supported and valued staff, creating a sense of common purpose based on shared values.

It was clear that an open, transparent, ‘no-blame’ culture had been established where the emphasis was on quality of care delivered to the patients. Staff we spoke with felt supported, respected and valued in their working environments and by senior staff.

During the inspection we noted staff being positive and caring towards patients and their relatives who used the service. In addition we also noted caring and respectful interactions between staff of all grades and disciplines.

We found the care and service delivered in the critical care unit showed a strong cohesive team approach to work. Administration staff and the unit cleaners told us they felt valued in their roles and felt very much part of the team. Staff we spoke with felt supported, respected and valued in their working environments and by senior staff.

Staff reported the multidisciplinary team worked effectively together, with staff across all teams respecting each other and working together to provide the best possible care and treatment to patients. The inclusive nature of the unit was demonstrated by multidisciplinary training sessions and governance meetings being open to all.

There was a strong ethos of team work and during the inspection we saw many examples of this, from nursing staff supporting each other at times of intense clinical need, consultants working as registrars to cover vacancies and staff supporting each other after a distressing incident on the unit.

To welcome and support staff that had joined the unit from abroad, there was an overseas support group. The group held monthly overseas staff coffee mornings which were seen as a way to support and understand the stresses some people may be experiencing. These coffee mornings were open to all and were seen as a good way to bring staff from all different nationalities together. During the inspection we saw posters advertising the next coffee morning. To further celebrate the diversity of the critical care team bunting depicting the national flags from the countries staff were born were displayed in the staff room.

As per NHS guidelines the trust had appointed a freedom to speak up guardian whom staff could talk to in confidence if they had concerns. Staff we spoke with were aware of the freedom to speak up guardian. We saw posters displayed in the staff room which explained about the freedom to speak up role and who and how to contact one of the speak up advocates for confidential advice and support. In addition, during the inspection the educational team were running a training session all about the freedom to Speak Up guardian service at the hospital.

There was a culture of learning and development, innovation and creativity within the unit.

**Governance**

The critical care unit had robust, well established and effective governance processes.

The critical care unit had a consultant lead for clinical governance and was supported by the critical care governance group. There were four main aspects to the group’s role, CQC
compliance, risk management, guidelines and standard operating procedures and audit program with the aim to maintain, improve and ensure accountability for high standards of care in the critical care department.

Departmental quality and governance meetings were held every two monthly and were open to all staff that worked in the unit. In this meeting all aspect of governance was discussed including quality issues of safety, risk, clinical effectiveness, and patient experience. An action plan was produced after every meeting and progress reviewed at the following meeting. We reviewed one set of these notes.

In the months between the quality and governance meeting the unit held its ‘Cake and Quality’ meeting. This meeting was for all critical care staff to get together and discuss quality and safety in the unit. We were told that the meeting usually focused on a topic, for example staff resilience and was well attended by all disciplines and grades.

We were told that information from meetings was disseminated down to staff in various ways, staff meetings, during handovers and safety briefings, on the intranet, in emails, newsletters and displayed on the dedicated quality and governance notice board.

Information was escalated up to the trust board via the CHAT CSC monthly board meetings, which the critical care team was represented by the clinical governance lead and the critical care senior management team. We reviewed three sets of these notes and saw that all aspects of the critical care service was discussed including safety, patient experience, effectiveness and compliance. In addition a critical care governance review was completed yearly.

The departmental structure was clearly laid out, staff understood the hierarchy and were clear about their roles and responsibilities. However, the new advanced critical care practitioner role was still to be embedded in the unit and some staff we spoke with told us more work was needed by the senior team to fully integrate this role into the unit. Regularly meetings were held by different staff disciplines and grades where they could discuss issues at their level. We reviewed three sets of minutes from the band 5 nurses and the consultants meetings and saw that all aspects of quality and safety were discussed.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Risks identified in the critical care unit were placed on the CHAT clinical service centre risk register. Currently there were eight risks relating to critical care on the register, three classed as speciality risk i.e. delayed discharges and out of hours transfers and five classed as local risks i.e. injury to staff by aggressive patients. Risks had review dates, who owned the risk, rating of risk and the current level of risk.

We were told by the critical care governance lead, who was responsible for risk management in the department with the operations manager that the risk register was continuously updated and risks were formally reviewed in the week before the departments governance meeting so feedback and updates could be presented.

The unit produced a top five risks poster, which gave details of the critical care’s five biggest risks and what the unit was doing to mitigate the risks. This was distributed to staff via email. The poster was also displayed on notice boards around the unit and on the watcher screens. Posters were updated following every formal review. We saw the current top five risks poster (dated March
Information management

The critical care unit collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The critical care unit had an audit lead who was responsible for coordinating the annual audit cycle, to facilitate identifying priorities for new and repeated clinical audits and to ensure distribution of audit findings and recommendations. The critical care unit also had a team who coordinated the data acquisition required by the Intensive Care National Audit and Research Centre (ICNARC).

We saw during the inspection the 2017-2018 audit plan, which included information on internal audits for example measuring the amount of physiotherapy rehabilitation patients receive, and information on external audits for example information required by the ICNARC.

Staff could use the critical care’s computer information system to monitor, display trends and record data. It also aided in the collection of data required for audit purposes. The IT team told us they were constantly trying to find ways to utilise IT to help staff and benefit patient care.

Staff had access via the unit’s computer information system to policies, procedures and guidance required when working in the critical care unit. During the inspection we saw staff using these points of reference and all commented on how easy it was to find the information on the system.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The trust encouraged public engagement. They offered the iWantGreatCare scheme for the public to feed back their comments and help improve the hospital services. They could do this on a paper form found in the departments or via the ‘contact us’ tab on the hospital website where patients could leave electronic feedback about their hospital experiences. In addition on the website there were links to both NHS choices and the patient opinion webpages. Again patients and the public could write their comments about the hospital.

At a critical care service level the unit carried out patient surveys and relative surveys. Information gathered from these surveys was used to facilitate improvement and maintain standards. We saw results from the latest relative survey (Dec 2017-March 2018) which showed an overall score of 94% satisfaction with the service received in the critical care unit.

In the critical care waiting room posters displayed information about the carers café. This was a once a month drop in session where people could go for a drink and gave them a chance to relax, talk to others and find support and information.

The critical care department had an informative webpage where the public could assess much information about the service; it gave an overview of the critical care unit, patient and visitor’s information and what to expect when visiting for the first time, detailed information on the critical care team, how to leave feedback and links to other helpful information.

Information was displayed throughout the critical care unit on notice boards, information screens and the watch-out screens for patients, relatives and staff. There was information on all aspects of critical care, including staff in the unit, safety thermometer results, patient and relative feedback plus specialist boards by the unit’s dietician, physiotherapist and renal team. The critical care had...
a strict policy with named staff responsible in making sure the information was current and regularly up-dated.

The critical care senior management team told us that staff engagement was important to them. They worked hard to make sure the unit was inclusive, open and transparent. The senior team had recently introduced a staff participation engagement and communication application, developed by another trust which had become known as the ‘happy app’ for staff. The app collected data from staff anonymously about problems and frustrations as well as positive experiences from their shifts. Senior staff could monitor and respond to issues quickly so they didn’t escalate but could also use information collected as an early warning tool to identify potential problems with patient flow and quality of care.

Staff we spoke with spoke positively about this app and the many other ways information was communicated to them, including the QUEST staff magazine, secure social media accounts, and staff meetings.

The critical care unit asked for staff evaluation after teaching and training sessions so effectiveness of training could be measured. Feedback was used to see how relevant a training session had been and make improvements if need be.

We were told by staff that the critical care unit was actively trying to engage with the rest of the hospital better. For example, to help with staff pressures critical care nursing staff had worked on the respiratory wards; the critical care outreach and retrieval teams worked throughout the hospital; and the critical care team had sought consultation from the general wards when designing the new patient discharge forms. This made sure the correct patient information was given to the ward staff to ensure seamless transfer of care. It was hoped by forming better working relationships within the hospital, this would improve communications and understanding between the teams and hence improve the patient journey through the hospital.

The critical care unit had delivered their own innovative website which was accessible to staff, general public and other trusts. On this site could be found the department’s safety notices, publications, guidelines and standard operating procedures as well as guidance, tutorials and online videos from recognised intensive care organisations. The ethos of the critical care unit was that the sharing of high quality information would benefit all.

**Learning, continuous improvement and innovation**

The critical care unit was committed to improving services by learning from when things went well and when things went wrong. The unit was forward looking, promoting training and research and encouraging innovations to ensure improvement and sustainability of the service.

The critical care unit had an active research program with three research nurses working in the unit. Patients that met eligibility criteria for studies would be asked or their relatives asked if they would like to participate. Current research studies running in the unit were detailed on the dedicated research notice board. Studies and information about the unit’s research team could also be found on the critical care webpage. Investing in research was seen by the unit as a way to influence and improve care in the future.

The Clinical lead for the critical care service was an editor for ‘The Bottom Line’ which is an online site where papers are reviewed and discussed within the critical care community.

The critical care IT team were continually looking for ways for digital media to enhance the critical care environment, to share information with staff, patients, relatives and other organisations. Their
initiatives were helping to improve the safety and quality of care given to patients in the critical care unit.

The critical care team were continuously trying to find the best ways to work and make improvements to their service. Since our last inspection in 2015 many improvements had been made this included: employment of a full time dietitian; increased the number of physiotherapists working in the unit; improved and extended the outreach service; updated the computer information system; looked at ways to improve patient flow; introduced a relatives bleep system; looked at ways to humanise the critical care environment to aid patient treatment and recovery.

The trust ran the 'best people' award scheme to give recognition to staff and volunteers who had given exemplary service. These awards acknowledged individuals and teams who had made a significant contribution to the patient experience. The critical care team in 2017 had won two of these awards, with best support going to the critical care administration team and the patients choice being awarded to the critical care follow up lead nurse.
Maternity
Facts and data about this service
Portsmouth Hospitals NHS Trust offered six places for women to give birth:

- Queen Alexandra Hospital, B8, a consultant led labour ward for women with high risk pregnancy or medical complications.
- A co-located maternity centre, B5, offering birth to low risk women, as well as antenatal and postnatal care, with four birthing rooms and two triage rooms.
- Blake Maternity Centre, based in Gosport War Memorial Hospital, with two birthing rooms.
- Grange Maternity Centre based in Petersfield Hospital, with two birthing rooms.
- Portsmouth Maternity Centre based in St Mary’s Hospital Portsmouth, with two birthing rooms.
- Home births.

The trust had 73 acute maternity beds at Queen Alexandra Hospital, located across four departments:

- Maternity assessment unit – five beds
- Antenatal ward B6 – 16 beds
- Labour ward B8 – 21 beds
- Postnatal ward B7 – 31 beds, with eight side rooms

(Source: Trust Provider Information Request – Acute sites and context)

From October 2016 to September 2017 there were 5,452 deliveries at the trust.

A comparison between the number of deliveries at the trust and the national totals during this period is shown below.

A profile of all hospital deliveries and gestation periods from July 2016 to June 2017 can be seen in the tables below:

<table>
<thead>
<tr>
<th>Profile of all deliveries (October 2016 to September 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PORTSMOUTH HOSPITALS NHS TRUST</td>
</tr>
<tr>
<td>Deliveries</td>
</tr>
</tbody>
</table>

(source: trust provider information request – acute sites and context)
<table>
<thead>
<tr>
<th>Single or multiple births</th>
<th>(n)</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>5,363</td>
<td>98.4%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>89</td>
<td>1.6%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s age</th>
<th>(n)</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>205</td>
<td>3.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,227</td>
<td>77.5%</td>
<td>75.1%</td>
</tr>
<tr>
<td>35-39</td>
<td>835</td>
<td>15.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>40+</td>
<td>185</td>
<td>3.4%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of deliveries</th>
<th>(n)</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,452</td>
<td></td>
<td>607,089</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

### Gestation periods (October 2016 to September 2017)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>PORTSMOUTH HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>7</td>
<td>0.1%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>438</td>
<td>8.1%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>4,941</td>
<td>91.6%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>7</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of deliveries with a valid gestation period recorded</th>
<th>(n)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,393</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
SOURCE: HES - Deliveries (October 2016 - September 2017)
For this core service inspection, we visited the maternity unit at Queen Alexandra Hospital, including the alongside midwifery led unit (B5), and two of the three standalone midwifery led units; Blake, in Gosport, and the Portsmouth Maternity Centre. The Grange unit in Petersfield was closed when we visited as there was no planned activity on that day, so we did not view this location.

We last inspected this service, in combination with gynaecology services, in 2015, and we judged it as good overall, with a rating of good for safe, effective, responsive and well led. We rated it outstanding for caring. For this inspection on 17 – 19 April 2018, we inspected maternity services only, in line with our current inspection process.

During our visit we spoke with 15 women and their partners and 41 members of staff. Staff included senior departmental staff, midwives and maternity support workers, non-clinical staff, doctors and managers. We also spoke with the lead for maternity engagement. We reviewed 10 sets of notes and a wide range of documents submitted by the trust.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff. The trust provided data on training compliance for midwifery staff but not for medical staff. We were not assured there was a robust process in place to monitor compliance with mandatory training across all staff groups.

**Mandatory training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of all mandatory training modules, aside from information governance which was set a target of 95%.

In maternity services qualified nursing midwifery staff met the target with 91% compliance overall.

A breakdown of compliance for mandatory courses for nursing midwifery staff from April 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>233</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>233</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>232</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>232</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>232</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>231</td>
<td>233</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>175</td>
<td>180</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>196</td>
<td>202</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>226</td>
<td>233</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>225</td>
<td>233</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training Program</td>
<td>Complete</td>
<td>Failed</td>
<td>Target</td>
<td>Met Target</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>225</td>
<td>233</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>172</td>
<td>207</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>133</td>
<td>182</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>144</td>
<td>202</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>133</td>
<td>189</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>113</td>
<td>180</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3,135</td>
<td>3,439</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing midwifery staff met the target in 11 of the 16 training modules, achieving 100% compliance in five modules. Staff failed to meet the 85% target in five modules, including adult basic life support where 144 of 202 eligible staff had completed the training.

(Source: Routine Provider Information Request (RPIR) - Mandatory training)

**Mandatory training completion rates - medical staff**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust have not provided this information.

(Source: Trust Provider Information Request P14)

The practice education team booked all staff onto both the trust updates for maternity staff, and practical emergency training for obstetric emergencies (PROMPT). The maternity trust updates were delivered over two days. In 2017/18 the service could only offer four dates for PROMPT training, and reported a total of 265 (or 78%) staff attended these courses (which included midwives, maternity support workers (MSW), obstetricians, anaesthetists and student midwives).

In 2017, the trust trained additional trainers to deliver this course, and was offering monthly training sessions for 2018/19. The training team also added sepsis and identifying acute, life threatening events to the PROMPT training, all delivered as scenario based courses. The trust planned to provide maternity support workers with an introduction to sepsis, using a case scenario, in 2018.

The PROMPT training also included perinatal mental health training, delivered by the perinatal mental health nurse specialist. Staff told us this had been informative and thought provoking. The service added it to the mandatory training programme for 2018/19.

Conflict resolution did not require annual updates and basic life support training was provided as part of the trust update. The trust had added training in learning disabilities to the 2108 /19 training programme, delivered by the specialist nurses for learning disabilities.

Although most staff reported good access to mandatory training, some reported that when the unit was in escalation they could not always attend training, but they would be booked onto the next available dates. The utilisation of staff in periods of escalation supported patient safety.

Staff could view their own record of training, so they could take action when training was due. They could access e-learning packages from home or at work.

**Safeguarding**

Midwifery staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwifery staff had training on how to recognise and report abuse and they know knew to apply it, although fewer had completed training in safeguarding children level 3 than the trust target.
Although asked, the trust did not provide data on medical staff compliance with mandatory training in safeguarding.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of safeguarding training. In maternity services qualified nursing midwifery staff met the target with 93% compliance overall.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for nursing midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>167</td>
<td>167</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>232</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>232</td>
<td>233</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>145</td>
<td>201</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>776</strong></td>
<td><strong>834</strong></td>
<td><strong>93%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Qualified nursing midwifery staff met the target for three of the four safeguarding modules with 100% compliance in each of the three modules. Staff failed to meet the 85% target for level 3 safeguarding children.

(Source: Routine Provider Information Request (RPIR) – Mandatory training)

**Safeguarding training completion rates - medical staff**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust have not provided this information.

(Source: Trust Provider Information Request P18)

The intercollegiate document on safeguarding requires midwives and doctors to complete safeguarding children training at level 3. To attain the level 3 competency, all midwives, doctors and maternity support workers were required to attend a four-hour, face to face, level 3 induction course and complete mandatory e-learning modules on child sexual exploitation (CSE) and female genital mutilation (FGM). The trust provided annual two-hour updates on the annual mandatory training days. Those clinicians who required ‘Specialist’ Level 3 were supported to undertake the additional training needed through bespoke training courses delivered in house and through the Local Safeguarding Children Boards. Fewer than 85% of midwives had achieved safeguarding at level 3. The trust did not provide data on medical staff and their completion of safeguarding training.

The trust had appointed a head of an integrated safeguarding team, covering adults, children and maternity. Maternity services had a safeguarding specialist and a named midwife for safeguarding who reported to the head of safeguarding and provided supervision across the clinical service group.
The trust ratified an updated safeguarding policy and procedures in April 2018, for adults, children and young people. It included guidance on domestic violence, PREVENT (preventing radicalisation), (FGM and CSE.

The trust reported revised governance arrangements for safeguarding, following guidance from outside agencies and reviews, and there was an overarching action plan in place to improve safeguarding procedures, including those for maternity staff. The integrated safeguarding committee reported to the board, under a revised governance structure. This new safeguarding committee had a remit to review cases and monitor action plans, to ensure improvements were identified and implemented. This process was still being embedded.

There had been five serious case reviews since 2014 with similar themes, relating to working effectively with social care partners and sharing information and learning. The report highlighted failures across the system including external partners. The service reported it had access to the child protection information sharing project, via the local authority to share information securely about vulnerable children.

The trust monitored safeguarding referrals and told us that between January 2017 and January 2018 (13 months) the women and children clinical service centre (W&C CSC) made 503 referrals, with 391 from antenatal women. The trust showed us that the trust’s maternity service had increased the number of referrals to the Portsmouth multi-agency safeguarding hub (MASH), indicating a raised awareness of and response to safeguarding risks. The rate of referral more than doubled from an average of 10 referrals a month in the first half of the year, to over 20 a month between October 2017 and January 2018.

Staff told us about the processes they would follow and were confident in identifying and referring a safeguarding concern. They were aware of who to contact if they required any safeguarding advice and support, and they carried out safeguarding assessments routinely. Staff used screening assessments to identify and support women, and share assessments and referral with other service professionals. Staff could view and allocate safeguarding alerts on the maternity IT system, although this system was not routinely used before a woman was 34 weeks pregnant, and was not a system shared with other health and social care professionals.

Midwives referred women assessed as a safeguarding risk to the CORAL team (changing outcomes, relationships and lives), set up in 2017 specifically to support vulnerable women. Midwives in the CORAL team were the safeguarding operational leads.

Following its implementation, the service had found the CORAL team could not support the high numbers of women referred to safeguarding, and the staff were unable to combine their on-call duties and maintain their skills, with their CORAL team responsibilities. At the time of inspection, the CORAL service was under review, to redefine appropriate referral criteria and agree roles, administration support and caseloads, to offer continuity of care.

The service had promoted safeguarding awareness amongst staff including supporting women and children in relation to FGM and CSE. The trust had issued guidelines for the identification and management of FGM in April 2018.

The service had identified the risk of having women’s named displayed on the whiteboard at the nurses’ station. This was on the risk register, and to partially mitigate the risk, women signed consent to have their names, or a pseudonym, displayed. This did not necessarily mitigate the risk, however, for women and their babies.
Cleanliness, infection control and hygiene

There was a lack of assurance the service controlled infection risk effectively. We observed that staff kept themselves, equipment and the premises clean. However, we were not given assurance that there were processes in place to review cleanliness and hygiene practices, to prevent the spread of infection.

We observed that most premises were visibly clean and staff had good access to personal protective equipment such as gloves and aprons. Staff followed procedures for the prevention and control of infection. They used hand gels and we observed staff cleaning their hands between patient’s contacts. There were hygiene handles on the entrances to the maternity unit at Queen Alexander Hospital, to promote the use of hand gel for staff and visitors. Staff adhered to bare below the elbow best practice guidance in the clinical environment.

However, we observed examples of poor infection control practice. We observed various paper posters and information sheets displayed on walls, which were not laminated and were secured by sticky tape or tack. We also observed a panel dislodged from the shower room wall, in the antenatal ward, and some rust staining around washbasin. These observations indicated a lack of robust scrutiny of infection control measures.

The ward cleaning checklists were not always signed as completed. For example on the postnatal ward B7, the checklist for w/c 19 March 2018 showed the daily cleaning of commodes was done once in the week, clinical equipment twice and not daily, and there was no evidence of cleaning individual rooms on the Monday or Tuesday that week. The checklists for B6 and B8 were completed to a higher standard and we saw ‘I am clean’ labels on items of equipment.

The hand held notes included prompts for screening women for MRSA and other infections. They did not include prompts to discuss the benefits of vaccinations against pertussis (whooping cough), or seasonal flu. The Royal College of Obstetricians and Gynaecologists (RCOG) advise pregnant women should have these vaccinations from their 20th week of pregnancy, or soon after their scan.

Midwifery staff had achieved 97% compliance with infection control training. We did not have data for medical staff training, which meant we were not assured there was a robust process in place to monitor medical compliance with mandatory training.

We reviewed the trust report on cleaning audits. For the four months January 2018 to April 2018, the three standalone birthing units and maternity theatres consistently scored 100%. Scores for Queen Alexandra wards were mostly below 100%, with scores of less than 85% (red rated) resulting from the monthly audits on two occasions. Improvements were shown on the following month’s audit.

The trust showed us the results of a hand hygiene audit in April 2018 for the Women and Children Clinical Services Centre (W&C CSC). Four midwives undertook the audit of 10 observations during the month. Results showed high levels of compliance, ranging from 91%-98%, for the seven aspects of hygiene observed. The report did not detail which areas were observed or what action was taken to address areas of non-compliance.

The service was unable to identify specific cases of puerperal sepsis due to the inability to interrogate their IT system. The service used a sepsis screening tool and would start the pathway if the woman showed the key symptoms. Their self-assessment for the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) audit identified the need to
update the postnatal discharge checklist to add in providing women with information on the signs and symptoms of sepsis. This was due to be completed by August 2018.

The women’s notes included prompts for midwives to discuss risks of tuberculosis and the benefits of BCG vaccinations for newborn infants. The trust had developed guidelines for the administration of the vaccine. There were also guidelines for the administration of the seasonal flu vaccine and whooping cough, however the documentation did not include prompts for midwives to discuss these with women.

**Environment and equipment**

For the most part, the service had suitable premises. The main exception was the Blake birth centre in Gosport where the birthing rooms required refurbishment. The trust told us there were issues with maintenance contracts for the peripheral sites and planned to review these in 2018/19. There was a lack of assurance that staff were competent with the use of equipment. Staff in the community did not have ready access to bilirubin meters.

At the Queen Alexander Hospital maternity unit, there was large postnatal ward (31 beds), which included eight side rooms. This ward was located between the antenatal ward and the delivery suite, with four side rooms for induction located near the entrance to the delivery suite.

The delivery suite had two high dependency beds and 14 delivery rooms. The baths in the ensuite bathrooms in the delivery suite were against the wall, which meant it would be difficult for staff to carry out an emergency evacuation.

The maternity assessment unit was located on the same corridor as the maternity unit. It had five beds and a large waiting area. The alongside midwife-led birthing centre (B5) was beyond the antenatal ward. This centre had three rooms, one with a birthing pool and appropriate equipment for the safe removal of the mother and baby in an emergency.

Near the labour ward, there was a bereavement suite. The staff had raised money to decorate and redesign this, to make it less clinical and more comfortable.

The Blake standalone birth centre in Gosport, with two birthing rooms, was in need of refurbishment. The birthing pool in one room was in the process of being removed. The other birthing room had damaged walls which presented a risk of infection control and did not present a homely environment. There was appropriate equipment for the safe removal of the mother and baby in an emergency. This centre had a large, well equipped area for breast feeding classes.

The Portsmouth maternity centre was more modern and spacious, and in a good state of repair. One of its two birthing rooms had a birthing pool. The unit had four clinic rooms and rooms where it provided breast feeding workshops and antenatal evening classes. We were not able to view the Grange birth centre, as it was closed when we visited.

We found the emergency trolleys, resuscitaires (used for warming therapy and resuscitation of a newborn baby) and emergency equipment were checked regularly staff signed to show they had completed this. There were labels on electrical items that showed they had been tested and there was a system to remind staff when checks were due.

The trust required staff to provide assurance they were competent to use the equipment, by completing self-assessment forms. However, the return rates of these forms were low. They varied from 67% from the hospital maternity support workers to 46% from community midwives. The service reported they aimed to improve compliance with the return of these forms, to monitor staff competency in using equipment.
Midwives prepared home birth equipment boxes, available at the standalone and alongside birthing centres. The checklists used in the sites were not identical, which meant there was a risk staff could make errors when checking the boxes.

The service reported a shortage of carbon monoxide testing equipment in the community, which affected their delivery of the smoking cessation programme. Staff assessed women’s risks from smoking at the hospital clinics.

There was secure entry to the wards and the standalone birthing units. Visitors had to request entry and staff monitored who entered the premises. However, we observed the milk preparation room on the postnatal ward was unlocked, as was the fridge that contained prepared infant formula. This meant there was a risk unauthorised persons could tamper with the milk.

The service provided us their equipment-servicing list, showing over 900 items of equipment, and their service and repair details. Almost all items had been maintained in line with the maintenance schedule. There were a few items on this list that indicated maintenance had not been completed. During our visit, we observed that of the eleven IV pumps in the B6 equipment store, ten were in date and one had been due a test in January 2018.

There was guidance for the evacuation of the birthing pool.

Staff reported they had mobile phones and used these for their lone worker safety, in line with the trust lone-worker policy. For staff security, midwives working remotely, outside normal working hours, let the nominated ‘beep holder’ know where they were.

The staff in community clinics did not have access to bilirubin monitors for jaundice monitoring. Staff had to carry out blood tests, so were unable to obtain a prompt result. Bilirubin monitors were available at the Queen Alexandra Hospital maternity unit.

**Assessing and responding to patient risk**

Midwives completed and updated risk assessments for each woman, and these became the women’s own hand-held notes. However, the use of the surgical checklist was inconsistent.

Midwives carried out assessments of women’s social, health and environmental risks at the booking appointment, recorded results in the women’s records and reviewed the information at subsequent appointments. Midwives took account of women’s medical history and any obstetric or gynaecological risks, when they met with women at their antenatal appointments. Women were also offered scans, to monitor growth and to test for an anomaly, and regular blood pressure, blood and urine tests.

We reviewed 10 sets of notes and these showed staff noted any social risks, such as vulnerable woman subject to domestic violence. There was also good evidence of the sepsis toolkit in use and completion of venous thromboembolism (VTE) assessments. There was a referral pathway for vulnerable women to the CORAL team of midwives, for specialist support.

When staff completed booking risk assessments there were agreed criteria to prompt obstetric advice. This was captured on a summary form, held by the service. An obstetrician reviewed the risk assessment to determine the overall level of obstetric risk. Higher risk patients were referred for additional screening and support.

Antenatal care included advice to women on monitoring fetal movements, and the service also provided support for women with gestational diabetes. The service had initiated carbon monoxide testing as part of the smoking cessation programme, but could not repeat these assessments at every contact due to a lack of equipment.
Women had details of numbers to call for advice or in an emergency. Midwives staffed the advice line, and they could refer women to the maternity assessment unit (MAU) for additional observations and scans, for example if women had concerns relating to fetal movements.

Women were admitted to the delivery suite for induction of labour as indicated by risk assessment. Staff prioritised the inductions, based on the nature of the risk and the capacity of the delivery ward. Although the unit aimed to invite women for inductions at staggered times during the day, to maximise capacity, some women reported long waits and dissatisfaction with the induction process.

The service used a revised observation chart for use in the maternity department to identify and escalate a deteriorating patient, based on best practice guidance. This was based on the local modified early obstetric warning score chart.

At the hospital, there were twice daily safety huddles and handovers where staff discussed each woman on the unit and any specific risk factors. We observed this approach worked well. Staff also maintained a visual record of women’s key risks (e.g. VTE, deterioration risk scores, any concerns) on the main whiteboard, and kept it updated.

We observed inconsistent use of the ‘World Health Organisation (WHO) guidelines and the five steps to safer surgery’ in the maternity operating theatre. The WHO surgical safety checklist is guidance to promote safety of patients undergoing surgery. This sets out what should be done during every surgical procedure to reduce the risk of errors. We observed two caesarean sections and found the team were not all present for the team brief and did not carry out a debrief. Previous audits in 2017, relating to deliveries in May-July 2017, showed inconsistencies with the completion of the swab checklist, and with the use of swab count stickers. We asked for WHO checklist audits and there was no evidence these had been carried out in the maternity theatres since the last never event in November 2017, which related to a retained swab.

Our review of records showed staff completed specific risk assessment tools, such as the sepsis screening tool. They also completed cardiotocographs (CTG), which are recordings of the fetal heartrate, and labour partograms. Partograms are records of the progress of labour for the mother and fetus, and are used to detect when labour is not progressing normally.

The midwives staffing the telephone ‘labour line’ supported and risk assessed women who called in labour. For those who had planned to birth at a midwife led unit there were guidelines to follow should risk factors increase and women needed to move to the delivery suite at Queen Alexandra Hospital.

If a higher risk woman particularly wanted to deliver in a midwife led unit, they met with the specialist midwife to develop a plan. We saw these plans were carefully developed to ensure the woman’s views were recorded as well as any risks and how they would be managed.

The service had a time critical transfer agreement with the ambulance service and monitored transfer rates. The transfer guideline was under review at the time of the inspection, and included categories for emergency, time critical or own car transfers, based on the midwife’s clinical assessment. Transfer rates were high from the alongside midwifery unit, B5, but low from the standalone units.

After the birth, the discharge coordinator read the discharge summaries to identify and highlight any risks, for further referrals. However, the postnatal records received at the postnatal clinics did not include the risk assessments for deteriorating women. We were told these charts were stored
at the hospital. This meant the midwives supporting women postnatally might not be in possession of the full obstetric history.

The postnatal pathway was for maternity support workers (MSWs) to visit women in their home. If they had concerns relating to the wellbeing of the mother or baby, they alerted the midwife. Women’s interactions with midwives might be by phone or at a clinic, if they chose to visit one. Community postnatal staff we spoke with commented that the process meant there was a lack of continuity of care, and a risk that staff did not recognise and act on small changes or trends.

**Midwifery and nurse staffing**

The service had recruited additional staff, and continued to recruit, to ensure there were enough midwifery staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

**Planned vs actual**

The trust has reported their staffing numbers below for nursing midwifery staff from April 2017 to March 2018.

Fill rates ranged between 88.9% to 94.2% during the period. As of March 2018, there were 15.0 fewer whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>210.4</td>
<td>196.9</td>
<td>93.6%</td>
</tr>
<tr>
<td>May</td>
<td>210.4</td>
<td>198.3</td>
<td>94.2%</td>
</tr>
<tr>
<td>June</td>
<td>214.4</td>
<td>199.8</td>
<td>93.2%</td>
</tr>
<tr>
<td>July</td>
<td>214.4</td>
<td>196.5</td>
<td>91.7%</td>
</tr>
<tr>
<td>August</td>
<td>209.8</td>
<td>196.5</td>
<td>93.6%</td>
</tr>
<tr>
<td>September</td>
<td>218.6</td>
<td>196.5</td>
<td>89.9%</td>
</tr>
<tr>
<td>October</td>
<td>218.6</td>
<td>203.1</td>
<td>92.9%</td>
</tr>
<tr>
<td>November</td>
<td>218.6</td>
<td>205.4</td>
<td>94.0%</td>
</tr>
<tr>
<td>December</td>
<td>219.4</td>
<td>205.3</td>
<td>93.6%</td>
</tr>
<tr>
<td>January</td>
<td>219.4</td>
<td>202.3</td>
<td>92.2%</td>
</tr>
<tr>
<td>February</td>
<td>219.4</td>
<td>203.5</td>
<td>92.8%</td>
</tr>
<tr>
<td>March</td>
<td>219.4</td>
<td>204.4</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

*(Source: Trust updated nursing data)*

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017 the trust reported an annual vacancy rate of 8.8% for qualified nursing midwifery staff in maternity.
The trust did not have a target vacancy rate but nursing midwifery staff had a higher vacancy rate than the trust total for all staff groups of 7.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

In December 2017 the trust reported a turnover rate of 10.4% for qualified nursing midwifery staff in maternity which is above the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported an annual sickness rate of 5.9% for qualified nursing midwifery staff in maternity, which is worse than the trust’s target sickness rate of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Midwife to birth ratio**
From October 2016 to September 2017 the trust had a ratio of one midwife to every 29 women, which is lower than the national average for that period of one midwife to every 27 women.

(Source: Electronic Staff Records – ESR Data Warehouse)

The head of midwifery reported the service had recently recruited 17 new staff, with 13 WTE vacancies and six applicants shortlisted for interview.

The maternity clinical scorecard showed that between April 2017 and March 2018 the service operated a midwife to birth ratio of between 1:23 (one midwife to every 23 women, in February 2018) and 1:31 (May 2017). Most months the ratio was 1:28, which is similar to the national average of 1:27.

Maternity services had planned staffing levels and operated an integrated staffing model, such that midwives usually work across both the midwife led units and the obstetric unit. Staffing levels were displayed on the wards at the Queen Alexandra Hospital and at the birthing units.

Staff reported there had been difficulties from having a history of staff shortages. They said they were moved to work in the delivery suite, for example from the post-natal ward if the shift was short staffed, and this had happened ‘fairly often’. The service monitored when staffing issues triggered the escalation policy. The clinical scorecard for maternity showed the escalation policy had been triggered on 30 shifts in the 12 months April 2017 to March 2018. The scorecard rated the impact of this as low if it occurred less than five times a month. The risk scores were low most months, but midwife staffing was rated amber in November 2017 and December 2017. In December 2017, nine shifts had been in escalation.
The maternity escalation protocol was amended in April 2018. An amber alert was triggered if there was a significant shortage of beds, with the implication of suboptimal staffing numbers/skills or a peak in clinical activity. This level was linked to a range of scenarios and mitigations included moving staff and offering women who had requested a home birth, or a standalone unit midwife led birth, to attend B5. A black alert would be triggered if all maternity services were at capacity or staffing could not guarantee 1:1 in labour (red alert) and the situation was unlikely to be resolved despite a range of possible actions. Under a black alert, the trust might decide to suspend the service, with senior management agreement and liaison with other providers, to maintain safety.

The service assigned a supernumerary ‘midwife in charge’ and lead midwives for day and night shifts, to coordinate the service, in line with Safer Childbirth guidance. The midwife in charge sometimes assisted with drug rounds, but the clinical scorecard showed they were almost always able to maintain a supernumerary role. Staff reported this approach worked well and the staffing allocations were well managed on a day-to-day basis. Senior midwives however said they had often been pulled from management days to support the staffing demands.

The unit had a consultant midwife, whose role was primarily associated with supporting vulnerable women and promoting safeguarding practices.

In the community, there were five labour call midwives at all times, supported by MSWs. Postnatal coordinators, midwives and MSWs provided postnatal care and community midwives provided antenatal classes. The staffing arrangement did not provide for backfilling, for example at times of high demand when community midwives were allocated to the wards. A senior midwife took the role as the ‘bleep holder’ on day and night shifts, based at the hospital.

Blake midwife led unit was staffed 8am-8pm, with one MSW between 5pm and 8pm. The unit only opened at night to support a woman in labour. To support births outside normal working hours, the service allocated staff and opened the unit. The service had developed services with student midwives, including postnatal ‘SMILE’ clinics, where the student midwives checked the mother and baby under the supervision of the community midwives.

At night the service allocated 15 midwives to the hospital and four to community services. Three midwives and one MSW worked on the post-natal ward (31 beds), one midwife on the antenatal ward with an MSW (16 beds), and nine midwives with two MSWs worked on the labour ward and induction bay. In addition, two midwives staffed the maternity assessment unit. The service reported all midwives were trained to support births at home, in the community and on the labour ward.

In the day, the postnatal ward (B7) was staffed with a lead midwife (normally supernumerary), four midwives and three maternity support workers. The ward also had student midwives. Staff said they sometimes ‘lost’ staff to the labour ward.

Theatre staffing included two operating department practitioners (ODPs) during normal working hours (Monday to Friday). There was one ODP at evenings and weekends. There was a dedicated team working in the recovery area up to 8pm on weekdays. There was a recovery practitioner to recover the mother and an MSW to look after the baby. At night time and weekends in an emergency, the midwife caring for the woman attended theatre as a scrub midwife and cared for the mother and baby in recovery, with support from a MSW, the attending anaesthetist and ODP. Some community midwives expressed concerns about working in the delivery suite, as they felt they did not have the confidence and experience even though they had a theatre training placement which covered the role of the scrub nurse/midwife and the recovery nurse.
Maternity services held a safety huddle every morning at the Queen Alexandra, attended by the head of midwifery and senior members of staff. This was not attended by obstetric staff. The meeting was used to share information about incidents, changes in practice and service developments. There were twice daily ward handover meetings where staff summarised key messages about the women on their wards. The huddle papers were shared electronically and the postnatal leads replicated the safety huddle in the community.

The service had a cohort of specialist midwives. For example, for diabetes, infant feeding, screening, perinatal mental health, bereavement and public health. It had also started to identify, train and develop staff as professional midwife advocates, in line with NHS guidance.

Medical staffing

The following is the information the trust provided for medical staff working in both maternity and gynaecology core services from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>41.3</td>
<td>44.9</td>
<td>108.7%</td>
</tr>
<tr>
<td>May</td>
<td>41.3</td>
<td>43.6</td>
<td>105.5%</td>
</tr>
<tr>
<td>June</td>
<td>42.3</td>
<td>43.6</td>
<td>103.0%</td>
</tr>
<tr>
<td>July</td>
<td>42.3</td>
<td>43.6</td>
<td>103.0%</td>
</tr>
<tr>
<td>August</td>
<td>42.3</td>
<td>38.6</td>
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</tr>
<tr>
<td>September</td>
<td>42.3</td>
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<tr>
<td>October</td>
<td>42.3</td>
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<td>42.3</td>
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<td>January</td>
<td>42.3</td>
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<td>97.5%</td>
</tr>
<tr>
<td>February</td>
<td>42.3</td>
<td>44.3</td>
<td>104.6%</td>
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<tr>
<td>March</td>
<td>42.3</td>
<td>43.8</td>
<td>103.4%</td>
</tr>
</tbody>
</table>

Fill rates ranged between 90.5% to 108.7% during the period. As of March 2018, there were 1.4 more whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care. The service was aware their medical staffing arrangements did not follow the Royal College of Obstetricians and Gynaecologists ‘Safer Childbirth’ guidance for obstetric cover. Staff reported that it was sometimes difficult to access a doctor and this caused delays in assessing women or obtaining prescriptions. The service provided a guideline on obstetrician attendance, dated 2012, which they said was under review.

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This was not received.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This was not received.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This was not received.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This was not received.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
In October 2017, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average. The proportion of middle career staff was lower, with 0% of the medical staff at the trust at middle career grade.

Staffing skill mix for the 40.2 whole time equivalent staff working in maternity services at Portsmouth Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>52%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

On inspection, the medical staff told us there were 10 consultants that provided obstetric services, and these staff also provided gynaecology. On the labour ward, the daily shift started at 8.15am, with a multidisciplinary handover, involving the coordinating midwife, junior doctors, anaesthetists and the neonatal obstetrician. There were board rounds at 1pm and at 5pm and a handover to the night consultant. The obstetric rota was created by the junior doctor’s liaison officer lead for Women and Children Clinical Service Centre (CSC) supported by two senior registrars. The trust advised they had weekly staff validation meetings (not minuted) to co-ordinate and prioritise staffing for the following two-week consultant rota.

This was the same at weekends, with additional ward rounds. At night, consultants provided on-call from home. They said they were rarely called to attend, but if required they could take the following day off and arrange ad hoc cover. Medical cover at night was provided by the junior
doctors. Although there was a consultant on-call rota, staff said the consultants very rarely attended. At the time of the inspection, it had one locum consultant post above establishment. At our last inspection in 2015 we asked the trust to review consultant cover on the obstetric consultant-led unit so that this is in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth (2007) recommendations.

Staff reported that shortage of on-site medical staff caused delays in reviewing women and issuing prescriptions, and this had sometimes resulted in complaints. At weekends, a second-year foundation junior doctor (F2) covered the labour ward, however staff reported that sometimes there was no doctor available when needed, which triggered an incident report.

On weekdays, whilst working in the labour ward, consultants did not carry out ward rounds on the antenatal or postnatal wards. The senior house officers oversaw the postnatal ward, and the women on the antenatal ward were seen by their own consultants, or deputising staff when they were not on site. There was no daily huddle for the medical staff on the postnatal wards. Staff told us the midwives needed to actively seek medical support when they needed it, as the allocation of consultant level cover on the antenatal and postnatal wards was not clear.

There was registrar support for the midwife led unit (B5) at Alexandra hospital. Midwives in the standalone units said they phoned for medical advice when necessary. As midwife led units, there was no medical support at the standalone units.

Medical cover for 24/7 maternity assessment unit was not always sufficient to provide prompt decisions. The unit combined an antenatal day unit with a triage service. There was consultant cover for the MAU between 8am and 8pm, Monday to Friday, and on call cover evenings and weekends. It was a busy unit and both women and staff reported delays to see a doctor. We were told that new consultants had been appointed.

There was a theatre huddle at beginning of each shift, to discuss each woman and the theatre list. The operating theatre opened at night for emergency caesareans, third degree tears and placenta removal.

**Records**

Staff created records of women’s care and treatment, however records were not consistently clear, up-to-date or easily available to all staff providing care.

The service produced paper based records, for example, women’s hand held records and discharge sheets. The main electronic system in use was no longer supported by the IT supplier, and the service used a range of different bespoke IT systems for different purposes, for example for antenatal care, or fetal monitoring and screening. This was on the service risk register. The service had recently received approval to purchase a new IT system, and aimed to implement a system that could link externally, within the local maternity system. Staff reported they wasted time inputting data and searching for information due to the complexity of the records process.

Midwives issued women with their own maternity records, for them to hold and manage, at their booking appointment. The pre-printed notes booklet was designed for use with digital pens, however staff did not use them in this way, to create electronic records, and used them as paper records. The booklets were not set up to provide a clear chronology of antenatal care.

Findings reported in the past year, from serious case reviews and root cause analyses, identified poor standards of record keeping. They raised issues of poor organisation of maternity records and a lack of detailed recording of discussions, options and care planning. The standard of record keeping presented a risk to the safe care and treatment of women.
A documentation audit in February 2017 found omissions in the documentation of advice from the lead midwife. The service action was to introduce stickers to help with documentation. We did not observe these in our review of notes and there had not been a re-audit of records to assess improvement.

We reviewed ten sets of records. We found they were variable in quality, with some showing omissions in key information about the women. We found gaps in the blood test records, with no explanations. In two sets of records, there was no evidence of completed birth plans or pregnancy care plans, including booking arrangements. In one set of records, we noted there was a delay in proceeding to a caesarean section due to theatre demands, but the risks associated with this delay, and how they were managed and communicated, were not clearly documented. The notes were not always in chronological order, which meant they were hard to read. In addition, there were loose-leaf entries, and not all entries were signed and dated. In some cases, hand written notes were not easy to read.

We observed that sepsis screening was clearly documented and if a woman’s wellbeing deteriorated, staff recorded their observations and interventions appropriately in the notes.

For women admitted to the hospital maternity unit, staff used a mix of paper records, with medicine charts and bedside observations, as well as the full set of notes kept in the trollies. Staff printed some of the electronic notes and included them in the postnatal record.

Postnatally, staff at the hospital emailed scanned copies of the discharge summaries to postnatal community teams. However, some notes did not include patient identifiers on each page, which meant there was risk of mixing up records for different women. We observed postnatal notes that did not include a named midwife or consultant.

Staff generally kept clear surgical records however we reviewed two World Health Organisation (WHO) checklist for surgery and found they had not been completed in full and in one case had not been signed by the surgeon.

**Medicines**

The service did not ensure that medicines were consistently stored securely or at the correct temperature.

Community and ward staff checked and recorded medicine fridge temperatures daily. However, we found concerns with the records in some areas. For example, one fridge in the hospital delivery suite recorded maximum temperatures above 8 degrees Celsius on seven occasions since 1 April 2018. We also found single ampoules of medicines (which require refrigerated storage) were kept in delivery rooms ready for use. Some of these should have had reduced expiry dates due to their removal from the fridge, but staff had not revised the expiry dates. At the Portsmouth Maternity Centre, the medicine fridge had recorded above the maximum temperature, and staff said they had alerted the relevant estates department but no action had been taken.

At the hospital, we found some medicines were stored in an unlocked drawer in a trolley in the corridor. The trolley was moved to a locked room during the inspection when the risk was pointed out to staff. In other locations we found secure storage of medicines.

A pharmacist attended the maternity unit at the Queen Alexander Hospital during week days. There was no dedicated pharmacy support at weekends which staff reported caused some delay in discharging women and their babies.
Midwives could give medicines listed on the Midwives Exemptions list, without prior prescription, in line with their medicine management policy. For example, the trust submitted authorised patient group directions (PGDs) for administrating the whooping cough vaccine and the seasonal flu vaccine.

The trust reported they carried out monthly medicines reconciliation checks, and found no concerns with the results.

Incidents

Staff understood and followed the incident reporting process. In some areas, staff told us they did not always report incidents because they did not feel reporting had any impact.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported one incident which was classified as a never event for maternity.

This was a surgical/invasive procedure incident meeting SI criteria and refers to a retained foreign object post procedure which occurred in November 2017.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in maternity, which met the reporting criteria set by NHS England from February 2017 to January 2018.

A breakdown of the incident types is shown below:

- Three maternity/obstetric incidents: baby only (this include foetus, neonate and infant)
- One surgical/invasive procedure incident
- One abuse/alleged abuse of child patient by third party

(Source: Strategic Executive Information System (STEIS))

PIR – 33 DoC applicable to maternity in 2017

There was a process and policy for reporting and recording incidents. Most staff said they used the internal system on the intranet and they received an email confirming actions taken in response to incident reports. However, some staff said they submitted incident reports relating to poor documentation on discharge, but had not been informed of any action taken. They also said they reported when there were insufficient staff, or in escalation, but that ‘not much can be done’.

Staff in the community told us they felt they were not made aware of incidents and learning as well as those working at the hospital.

Feedback from medical staff was they felt there was a blame culture and there was not an effective process for learning from incidents. They received power point presentation or learning posters but the opportunities for reflective practice were variable. Medical staff did not attend the daily safety huddles.

Within the hospital, staff said they learnt about incidents at the safety huddles, and via emails. Midwifery staff gave an example of learning from a medicines incident. As a result, a system had been set up at the hospital to allocate a midwife at the start of each shift to check women had received their medicines at the correct times.
We observed a daily maternity safety huddle at the hospital and senior staff highlighted incidents, and learning from incidents. The trust provided a summary report of the issues raised at the January 2018 safety huddles, highlighting key action points, including learning from incidents. It was not clear when and how often these summary reports were produced and not all staff were aware of them. There was a risk that learning might not be shared more widely, across all teams of staff including medical staff.

The service held weekly governance meetings to review medium risk incidents and next-day panels for serious incidents or deaths. The ‘serious event review group’, chaired by the deputy head of midwifery, reviewed incidents relating to maternity, gynaecology and paediatrics. The trust executive panel reviewed any serious incidents.. Medical staff commented that there was variable skills and training for root cause analysis, to investigate serious incidents.

The trust provided the five action plans resulting from the serious case reviews relating to maternity. These reviews included action pans. Where actions were still in progress they were coordinated by the named midwife for safeguarding. Some improvements had been implemented for example coordination, quality and oversight of safeguarding referrals. However, the broader areas for improvement relating to service delivery and information sharing had not been completed.

The maternity service reviewed perinatal morbidity and mortality. In April 2018, the agenda for the bi-monthly obstetric governance meeting was amended to include maternal morbidity and mortality as part of the session.

Prior to this, staff reviewed perinatal morbidity and mortality. They did not minute the meetings but produced ‘watch out’ posters, which they sent to all staff and displayed on notice boards. Examples related to a range of conditions or situations that had contributed to mortality or morbidity. The posters provided learning points for staff.

We reviewed root cause analysis reports for three serious incidents which were of inconsistent quality. We observed a high level of parental input in one review, but in another, it was not clear if duty of candour had been shown. The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. The investigation reports did not make it clear this was carried out.

Midwives said there was an open culture that encouraged staff to apologise and report incidents when things went wrong, and they understood the principles of the DoC.

**Safety thermometer**

The NHS maternity safety is a measurement tool for improvement that focuses on perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It aims to measure ‘harm free’ care, and is assessed on a single day each month by surveying postnatal mothers.

The maternity clinical scorecard provided monthly data on a range of safety parameters including readmission for feeding concerns, transfers, stillbirths as well as the number of post-partum haemorrhages, and the blood loss. For the year to March 2018, the service scored amber or red every month bar one for the number of women who experienced a blood loss of 1000-2000mls from a vaginal birth, as a percentage of the number of births. The percentage of third and fourth degree tears was between 1.7% and 3.7% which was comparable with national benchmarking levels.
The trust W&C CSC dashboard showed top-level data across the care group, and included never events, falls, emergency caesarean sections and patient safety events, by month. The report did not include safety events specific to maternity services, such as those used in the maternity safety thermometer.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance. However, the service had not reviewed all their guidelines according to their review dates, to ensure they were up to date and in line with best practice and national guidance. There was an improvement plan to achieve compliance with national guidance.

The service had a range of guidelines available on the intranet for staff to follow, however many of these were marked as overdue a review. The service had not reviewed all these guidelines, to ensure they were up to date and in line with best practice and national guidance, such as that provided by the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidance.

Of the 88 guidelines on the trust intranet, 47 were flagged as red and in need of a review. These included the labour ward handbook for junior doctors and locums, breech management, the modified uterine rupture guideline and intrapartum fetal heart monitoring guideline bridging. The newborn examination guideline was issued in 2016 without reference to national guidance. The clinical risk assessment guidelines had a review date of May 2017 and the antenatal pathway we saw was last revised in 2014. The water birth emergency evacuation flow chart included guidance for the use of both the hoist and a net, but did not specify the frequency of simulation training exercises.

We saw revised and reviewed guidelines and pathways for intrapartum care (reflecting NICE Clinical Guideline CG190), and reduced fetal movement (NICE QS 22). The trust also had guidelines on the administration of antenatal and postnatal Anti D, revised to reflect 2016 NICE guidance. The post-partum haemorrhage guidelines (2015) reflected the guidance from ‘Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE).

The service had 16 care pathway algorithms available for reference on the maternity assessment unit (MAU), for example for bleeding in pregnancy, urinary infection, falls in pregnancy, hypertension, reduced or absent fetal movements. These were clearly presented and evidence based.

There was an established service to manage the care of women with perineal tears, and to support pregnant women who had experienced tears from previous births. This reflected the RCOG guidance on the management of third- and fourth-degree perineal tears.

There was NICE guidance to promote smoking cessation during pregnancy and after the birth. The Saving Babies Lives Care Bundle (NHS England 2016) recommends midwives have the training, time and the tools to carry out carbon monoxide (CO) tests at antenatal booking, and refer them to the smoking cessation service. Staff in the MAU offered the CO test when women attended for their 13-week scan. The service had submitted a business case for the purchase of additional CO monitors for use more widely, and had planned to deliver specific training to staff, pending a funding allocation. The trust safety improvement plan, updated in April 2018, stated that they had tested 43% of all women, due to equipment issues.
The Saving Babies Live Care Bundle also recommends monitoring fetal growth by carrying out regular ultrasound scans. The maternity service’s improvement plan (updated April 2018) highlighted that scan capacity did not support full implementation of this recommendation.

The service had an effective system for identifying women with risk factors for gestational diabetes, and provided tailored support as highlighted by MBRRACE-UK (2015) and in line with NICE guideline NG3 2015. The specialist midwives supported women during pregnancy, shared information with their GP and followed them up after the birth.

The service had set up a ‘caesarean section pathway’ for women choosing a caesarean birth. A trained maternity support worker met with women before their caesarean and followed them through to provide post birth support. There was an enhanced recovery pathway, managed by midwifery support workers.

The service had set up 11 governance review groups, called PODs, for reviewing clinical pathways against national guidance to ensure best practice. The clinical audit report showed the service had identified five NICE guidelines where they were not fully compliant. These included CG192 antenatal and postnatal mental health, QS35 Hypertension in pregnancy and NG3 Diabetes in pregnancy.

The trust showed us the service had audited breastfeeding support on the postnatal ward in 2017. The audit highlighted weaknesses in the documentation and use of the tools regarding breastfeeding. The final actions were for staff to improve communication and complete documentation.

**Nutrition and hydration**

Staff gave women enough food and drink to meet their needs.

Women said they were satisfied with the food and drink provided. They said they were offered a choice of diets and were also encouraged to have plenty of fluids.

Midwives gave women informed information on their choices on how to feed their babies, whilst encouraging breastfeeding as offering the most benefits. They offered support with breastfeeding and provided breast-feeding clinics in community setting. Maternity staff assessed how women managed to feed their babies following birth and again at the subsequent post-natal appointments.

The service had up to date guidelines on supporting women with both breastfeeding and with artificial feeding, based on best practice guidelines such as the Baby Friendly Initiative and Start4Life. Staff had to complete competency assessments before they could offer women advice. There were also guidelines for staff in how to monitor neonatal weight loss and actions to take.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain.

Women said they received good pain control and understood options available to them. The service’s 2017 postnatal pain management guidelines included guidance on analgesia. As part of the birth plan, midwives discussed and noted women’s views on types of pain relief, such as Entonox (gas and air), injection of an opiate painkiller, an epidural central nerve block or the use of a birth pool. There were birth pools at each of midwifery led unit, and the delivery rooms all had baths women could use for pain relief.

At the main obstetric unit at Queen Alexandra Hospital, there was 24-hour anaesthetist cover on the delivery suite. If they were supporting woman with an epidural then a second anaesthetist could be called to attend if required.
Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

National Neonatal Audit Programme

In the 2017 National Neonatal Audit the Queen Alexandra Hospital’s performance in the two measures relevant to maternity services was as follows:

- Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?
  
  There were 173 eligible cases identified for inclusion, 88.3% of mothers were given a complete or incomplete course of antenatal steroids.
  
  This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.
  
  The trust met the audit’s recommended standard of 85% for this measure.

- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?
  
  There were 59 eligible cases identified for inclusion, 67.8% of mothers were given magnesium sulphate in the 24 hours prior to delivery.
  
  This was higher than the national aggregate of 43.5%, and put the trust in the top quartile of trusts.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

From July 2016 to June 2017 the total number of caesarean sections and standardised caesarean section rates for both elective and emergency sections were all similar to expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)
In relation to other modes of delivery from July 2016 to June 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Portsmouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,657</td>
<td>29.8%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>508</td>
<td>9.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,393</td>
<td>61.0%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>7</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,565</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

The trust had a slightly lower rate of instrumental deliveries than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of January 2018 the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.86. This is up to 10% lower than the average for the comparator group rate of 6.4, which makes them better than expected.

This is in line with the previous publication where they were also up to 10% lower than the average for the comparator group.

(Source: MBRRACE UK)

Overall, the service participated in national audits and undertook local audits. There was a theme of poor documentation in the audit findings yet there had been no overarching review of the quality of documentation and how it was used. The maternity service’s audit programme for 2017/18 showed some of the ad hoc audits were behind schedule, and that actions were not always completed or monitored effectively. The action plan tracker showed audits with completion due dates of 2016 which had not been completed or closed. This meant the audit process may not be effective in bringing about improvements in practice.
The trust advised the results of the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) - perinatal mortality audit showed it had partially met two of the six recommendations and was fully compliant with four. The service had provided human factors training as part of the PROMPT training day, and had plans carry out an audit of inductions in labour.

The service participated in the National Maternal and Neonatal Health and Safety Collaborative, which was developed to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during, or soon after birth by 20% by 2020 and 50% by 2025. This is a national survey looking at staff and service views on the safety culture.

An audit of the elective caesarean section rate for August 2016, completed in March 2017, identified concerns with documentation, the lack of referral to specialist clinics for women who request a vaginal birth after a previous caesarean (VBAC clinic) and support for women after a traumatic birth. The service had established regular VBAC clinics and we spoke with women who gave positive feedback about the support they had received from this service.

The trust reported reduced rate of stillbirths, from over 25 a year in 2013, 2014 and 2015 to 21 in 2016 and 13 and 2017. The service considered the 24/7 maternity assessment unit and the ‘Saving Babies Lives Care Bundle’ helped bring about this improvement in outcomes.

The National Diabetes Audit - Pregnancy in Diabetes (continuous) showed an increase in the numbers of mothers with diabetes, against a falling birth rate. The service had set up a diabetes referral pathway with targeted care provided by specialist midwives. They met with women fortnightly to discuss diet, their birth plan and to monitor fetal growth. Staff reported this had helped reduce the stillbirth rate.

The service reported an increased rate of induction of labour. They attributed this to following the fetal movements pathway, in response to the Saving Babies Care Bundle. The service had planned a local audit to investigate delays in induction, having recorded incidences when there had been a delay of six hours in progressing the induction after initiation, due to demand/capacity in the delivery suite. One woman we spoke with reported they had experienced this and it had caused distress. The audit was planned for April 2018.

The national maternity and perinatal audit (NMPA) data published Dec 2017 highlighted the trust as an outlier for postpartum haemorrhages above 1500mls. The trust had initiated a review of this result.

Staff had carried out a breastfeeding support audit, on the postnatal ward, in July 2017. The results identified poor completion of the breastfeeding monitoring tool, as well as issues with the documentation used. The service issued a reminder to staff on how to complete the tool.

The local Maternity System (LMS) found the trust performed better than expected for the percentage of women who received an ultra sound examination by 13 weeks gestation (73%).

The service undertook annual swab count audits following normal deliveries. The audit of 50 sets of notes in 2017 showed a decline in the use of swab count stickers at delivery and an overall low level of compliance with the process.

**Competent staff**

**Appraisal rates**
From April 2017 to March 2018, 86% of staff within maternity at the trust had received an appraisal which was better than the trust target of 85%.
A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>30</td>
<td>28</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>96</td>
<td>86</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>227</td>
<td>190</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>353</strong></td>
<td><strong>304</strong></td>
<td><strong>86%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Qualified nursing midwifery staff were the only staff group who failed to meet the 85% target although this was only by one percent.

Please note that no medical staff data was available for maternity.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The service’s maternity practice education team provided staff with training guidance that included a comprehensive list of essential training needs, emergency training programme and maternity trust updates. Staff reported good links with the practice educators, but there had been some slippage in the delivery of community skills due to capacity.

The service provided specialist courses for staff for example in GROW (a standardised way of measuring fetal growth), enhanced maternal care, Downs Syndrome and mental health support. All midwives attended a practical suturing workshop using prosthetic and bovine tongues. It included revisiting anatomy and physiology, referral processes, delivery techniques and FGM.

Newly appointed staff gave positive feedback on their induction and orientation. For example, a newly qualified midwife described the corporate induction and said they had worked in a supernumerary capacity for four weeks, and was on a one year preceptorship. They said they had good support and were given opportunities to be the second midwife on home births and at the midwife led units.

The service planned to adopt NHS England’s midwifery supervision model, to replace the statutory supervision of midwives that ceased in April 2017. The plan involved training six professional midwifery advocates (PMAs), 12 midwifery advocates and six advocates from the MSW staff, as part of the RCM Caring for You campaign. At the time of the inspection, the service had four PMAs had almost completed their training.

Midwives undertook a 3-week training course in the maternity theatre, and a shift in recovery and in gynaecology observing a hysterectomy, to train as the scrub midwife. The service only routinely had recovery nurses for elective caesareans and midwives undertook recovery duties outside normal hours. Some midwives said they did not feel they had sufficient training for this role or competency in airway management. Maternity services had not developed a comprehensive competency programme for midwives in operating theatres. There was a risk that midwives did not have the necessary skills and experience to support women in recovery following a general anaesthetic caesarean section.

The MSWs said they had clear job specifications, defining what their roles. They completed competency assessments, for example in supporting breastfeeding, hand expressing milk and in preparing bottles of powdered formula milk.

The trust did not provide data on the appraisal rates for medical staff.
**Multidisciplinary working**

There was not a strong culture of multidisciplinary working. Some midwifery staff in the community said they felt marginalised. Midwives commented on the poor level of engagement by many of the obstetricians, for example in POD meetings or with postnatal community teams.

However, staff reported receiving good support from mental health staff, who had provided a perinatal mental health awareness day for maternity services.

The service had developed transfer agreements with the ambulance service and reported close link with social care services, health visitors and medical specialists. It had met with the Family Nurse Partnership leads and health visitors of a neighbouring trust to review referral pathways.

Staff used the Situation Background Assessment Recommendation (SBAR) tool to communicate between team members and promote safety. The tool included standardised prompt questions to ensure the information being shared was clear and effective in an emergency situation. We observed the SBAR tool in women’s records.

**Seven-day services**

The maternity service provided 24-hour care for women, seven days a week. The service was configured around the maternity unit at the Queen Alexandra Hospital, where there was the 24/7 maternity assessment unit, antenatal, postnatal and labour wards.

If a woman requested to give birth in a community midwife led units, they could call the labour line 24/7 and request this at any time. At Blake and The Grange units, the porters had to open up the building outside normal working hours and the maternity service allocated a maternity staff to the unit. Similarly, community midwives supported women with home births 24/7.

If women had concerns about their pregnancy or baby the service offered a 24/7 midwife-led advice line.

The operating theatre was available 24/7. At night the theatre team carried out emergency caesareans, third degree tears and placenta removal.

The trust had a consultant paediatrician available 24/7, in the hospital or via switchboard when on call from home. Both paediatric middle grade and junior grade doctors were resident 24/7 on a bleep and carried a crash bleep for emergency calls. The trust had a ‘massive obstetric haemorrhage protocol’ and the service could access specialist haematological services out of hours.

The service had access to imaging out of hours and midwives trained in sonography provided additional cover for the ultrasonography and obstetric scanning provision including on Saturdays.

The trust operated an on call mental health service.

**Health promotion**

Staff supported women to live healthier lives and helped them provide a healthy start in life for their babies.

This was through their work on smoking cessation, referral to perinatal mental health support and help with infant feeding. Staff also discussed the benefits of vaccination. The service also offered women support with gestational diabetes and referred them to their GPs for ongoing medical support.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Midwifery staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They followed trust policy and procedures when a woman could not give consent. Although the booking form did not include specific prompts to assess and record mental capacity to make decisions, it did include questions about a patient’s mental health, psychiatric disease, puerperal psychosis or learning difficulties.

• We did not receive medical staff training data for mental capacity and Deprivation of Liberty Safeguarding (DoLS).

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty training. In maternity services qualified nursing midwifery staff met the target with 96% compliance overall for the four relevant training modules.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for nursing midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>231</td>
<td>233</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>231</td>
<td>233</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>184</td>
<td>200</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>171</td>
<td>187</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>TOTAL</td>
<td>817</td>
<td>853</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory training)

Trust guidance on normal labour and birth stated that midwives must listen to women’s wishes relating to an emergency transfer and obtain consent. If a woman chose not to follow the advice, there was guidance for midwives to respect and record this decision and report it as an incident.

We reviewed 10 sets of records, including those of women with complex medical and/or social histories. There was evidence of consent being sought from women, for example, for a caesarean section, for the administration of vitamin K and for daily postnatal home visits where this was recommended. There was not always clear narrative to show staff explained the risks and benefits of different birth options, due to the nature of the record format.

If women chose a birth option that clinicians advised was not their safest option, we saw the service confirmed in writing what had been discussed, the reasons for their recommendations and what the woman had agreed to. These were detailed letters, supporting the women’s preferences and explaining the risks.

The hospital had access to a Mental Health Liaison Consultant Psychiatrist for specialist second opinion. Where a patient was assessed as lacking capacity then the service carried out a Deprivation of Liberty Safeguard (DOLS) application and a “best interests” path could be taken to facilitate care.
Is the service caring?

Compassionate care

Friends and Family test performance
Friends and family test performance (antenatal), Portsmouth Hospitals NHS Trust

From December 2016 to December 2017 the trust’s maternity friends and family test (antenatal) performance (% recommended) was better than or in line with the England average, ranging from 93% to 100%, with five months in the period reporting 100% recommend.

Friends and family test performance (birth), Portsmouth Hospitals NHS Trust

From December 2016 to December 2017 the trust’s maternity friends and family test (birth) performance (% recommended) was slightly better than the England average, ranging from 97% to 100%, with four months in the period reporting 100% recommend.

Friends and family test performance (postnatal ward), Portsmouth Hospitals NHS Trust

From December 2016 to December 2017 the trust’s maternity friends and family test (postnatal ward) performance (% recommended) was better than or in line with the England average for 11 of the 12 months, ranging from 92% to 99%. June 2017 saw the trust’s worst performance and fall slightly below the England average.
Friends and family test performance (postnatal community), Portsmouth Hospitals NHS Trust

From November 2016 to December 2017 the trust’s maternity friends and family test (postnatal community) performance (% recommended) was slightly better than the England average, ranging from 94% to 100%, with seven months in the period reporting 100% recommend.

CQC Survey of women’s experiences of maternity services 2017
The trust performed worse than other trusts for one of the 19 questions in the CQC maternity survey 2017, and about the same as other trusts for 18 questions.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>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?</td>
<td>About the same</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>8.9</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>Worst performing trusts</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>About the same</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged</td>
<td>About the same</td>
<td>6.0</td>
</tr>
</tbody>
</table>
from hospital?

Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?

Thinking about the care you received in hospital after the birth of your baby, were you given the information and explanations you needed?

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?

Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking about response time, if attention was needed after the birth of your baby, did a member of staff help within a reasonable amount of time?</td>
<td>About the same 7.5</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information and explanations you needed?</td>
<td>About the same 8.0</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same 8.3</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>About the same 4.8</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same 9.2</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Staff cared for women with compassion. Feedback from most women was that staff treated them well and with kindness.

Women told us felt staff were kind, and had a lovely attitude. They said their experience of antenatal care had been good, and they had attended clinics and classes. They said they had received the right amount of information at the right times, and had not felt rushed. One woman said she had a previous birth at the Queen Alexandra, and had received ‘amazing care’ both times, and the staff had been excellent.

Women spoke positively of the help line they had phoned before coming to the hospital. They said the staff provided clear advice in a kind way, and encouraged them to phone again when they wanted to. One woman said this meant they did not come into hospital too early and they were grateful for that.

We observed how staff discussed and managed a difficult situation on the delivery ward. Staff spoke very sensitively, showing compassion towards the woman, their family and fellow staff members.

When referring to a women with complex social history, staff displayed an understanding and non-judgemental attitude. We also noticed that written notes reflected sensitivity and understanding.

We observed staff introduced themselves and respected people’s privacy and dignity.

The service displayed feedback from women, and one comment was from a women who wrote they were grateful for the kindness shown when allowing their husband to stay overnight when they had been anxious.

An annual review of patient feedback showed the number of patients who would recommend the maternity service had remained constant at 98.9%, and above the national benchmark of 96%.
Emotional support

Staff provided emotional support to women to minimise their distress.

We observed staff anticipated the emotional support women might require and discussed how best to provide it. One woman we spoke with she had been anxious and was very grateful the service made it possible for her partner to stay overnight. Another commented their midwife had helped them relax.

As part of the antenatal assessments, midwives talked with women about their mental health and emotional state, in line with NICE quality standard (QS115). The perinatal mental health team provided specialist support in assessing and managing women’s mental well-being.

The service provided a debrief service for women if they requested one. We saw an example of a debriefing record, with the woman and her husband.

Understanding and involvement of patients and those close to them

Staff involved women and those close to them in decisions about their care and treatment.

Most women said they were well informed by the maternity staff they encountered and felt they were fully included in any discussions regarding options. Most understood what had happened with their care, and knew what to expect next.

One woman however felt they did not receive information about their care and she and her partner said they had not understood what was going on. Having been admitted very early in the morning for an induced labour, following the advice of the doctor on the MAU, the induction had started but then delayed. They were told this was because the labour ward was full. They did not understand the impact of the delay on the woman’s labour, and they had not felt reassured. They remained on the antenatal ward for over two days, and had a caesarean section. Once in the labour ward, she said her care had been ‘spot on’.

The Picker National Maternity Survey report 2017 stated that the service was above national average for involving women in decisions about antenatal, labour and birth. The report also stated the service was above average for women seeing their preferred midwife in the antenatal period.

We observed interactions at a clinic and staff provided clear information and invited discussion about women’s preferences. They answered questions and gave women opportunities to consider their options.

Staff told us they had used interpreters or a telephone translation service, when necessary. They also had access to picture guides and advocacy services. They had good access to perinatal mental health specialist services and diabetes services and staff explained how they tried to ‘normalise’ this type of specialist care for women. One women who attended diabetic clinic said they felt they had received very good support and it was ‘worth travelling’ for this type of care.
Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy
From Q2 2016/17 to Q3 2017/18 the bed occupancy levels for maternity were higher than the England average in all periods, with the trust having 80.5% occupancy in Q3 2017/18 compared to the England average of 58.9%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Maternity services were planned in collaboration with those of neighbouring trusts, and women had 24/7 access to services. However, women could not always give birth in the place of their choosing.

The service offered women with an uncomplicated pregnancy the choice of a home birth or a birth in the midwifery led units. There was a staffing model to support these models of care, however in practice, there were times of high activity, when the service could not allocate staff safely to community births and so women were directed to the alongside unit or labour ward. The service risk assessed each labour to ensure that every woman in the service was safe. The service planned to carry out more detailed audits to determine how often women did not gain their preferred choice or birth, and the reasons for this. The service data showed an increase rate of caesarean section and an increased induction rate, with still within the expected range.

The service was part of the SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) Local Maternity System (LMS). Within this collaboration it was working to deliver the Better Births objectives and to design services to meet the needs of women and their families. The LMS plan had been sent to NHS England for review. Part of the trust’s service strategy included the development of a single point of access to SHIP maternity services, with shared IT systems.

The trust’s strategy was based on ‘Nurture’, to ensure ‘the right people were in the right place at the right time’ and to ensure they provided women with 1-1 care and additional support for vulnerable women with complex needs.
The hospital maternity unit had 16 antenatal beds, 21 beds on the labour ward, including four for induction, 31 postnatal beds and the maternity operating theatre. The MAU and neonatal units were near to the maternity unit. There was a bereavement suite at the Queen Alexandra Hospital with a delivery room, sitting room and kitchen.

The service promoted the telephone labour line, which was a centralised midwife-led service, for three acute trusts, operating 24 hours a day.

The hospital and midwife led units offered a range of information sessions for parents. For example, staff delivered antenatal classes, breast feeding support and clinics, new infant physical examinations (NIPE) and parenting classes. These were offered at different times and locations to encourage attendance. For example, the service provided antenatal breastfeeding workshops at the hospital during the day on a monthly basis and bimonthly in evenings at maternity centres. The service offered monthly parents education classes in evenings (2 sessions). At Portsmouth Birth Centre, there were a range of mid-wife led clinics, including one for new infant physical examinations (NIPE), which meant parents did not have to travel to the main hospital. The centre offered a pre-booking clinic, for women under 10 weeks gestation, and ‘meet the midwife’ sessions for women at 14 weeks. Additional support was offered including classes for parents in the daytime at community centres, such as dance classes, coffee and chat, sing a long and pilates sessions.

The trust website had links to information about maternity services on the front page. Their website included contact details and maps for local maternity centres, and a link the ‘My Birthplace App’, to help women choose where to give birth. This app was also promoted in the women’s hand held notes.

When they booked their first appointment with the midwives, women received their hand held notes and a limited range of printed NHS leaflets. These included guidance on screening tests and ultrasound scans. The trust issued information for mothers on topics such as breastfeeding, FGM, nutrition, bruising and bonding. There were no leaflets about the trust’s specific services, however women were signposted to the website.

The trust had launched the Baby Buddy app in November 2017, with information and resources for parents through pregnancy and the first year of their baby’s life. The trust had also set up a webpage about maternal emotional wellbeing, to help women and partners recognise their own wellbeing and to signpost them to further support.

The service’s CORAL team supported vulnerable women during their pregnancy and birth.

**Meeting people’s individual needs**

The service took account of women’s individual needs of people in vulnerable circumstances however recording of individual birth plans was inconsistent.

The hand held notes included prompts for the booking midwife to explore any communication, language, hearing and speech concerns and mobility constraints. There was space, albeit limited, to provide detail on the person’s specific needs and preferences. Additional queries included medical history of mental health conditions, and careful assessment of social factors that could suggest vulnerabilities.

The maternity service staff had access to language line and a picture guide to help with translation and communication. Staff also reported requesting interpreters when it was appropriate.
The service offered complex care planning clinics for women with actual or potential complex pregnancies. Women were supported by the perinatal mental health specialist midwife to develop a personalised care plan. The service showed us two anonymised birth plans from the complex care clinic, which were detailed, clear and comprehensive. They referred those with moderate to severe mental illness to specialist perinatal mental health teams in the community or to the mother and baby unit.

The midwives in the CORAL team had close links with social services, health visitors and other groups supporting women. The midwives met with women at their homes or in the clinics, and made appointments to meet their particular needs. The CORAL service was under review at the time of the inspection to determine how best to support vulnerable women with one-to-one support through pregnancy and labour.

The maternity service’s updated action plan to improve health services for looked after children and safeguarding showed the service planned to revise the maternity hand-held notes to improve the risk assessment process for vulnerable women. They planned to embed the safeguarding and child sexual exploitation risk assessments into the new notes template, from April 2018, in liaison with partner agencies/social care services in Portsmouth and Hampshire.

**Access and flow**

Women could access maternity services when they needed it, with access to 24/7 telephone guidance and prompt responses, however, they did not always have access to the birthing unit of their choice.

The labour line provided an opportunity for the service to triage women and offer advice including during early labour. Women we spoke with had found this a useful service, with staff helping them understand how their pregnancy or labour was progressing.

The maternity assessment unit (MAU) was open 24/7. Women could phone for advice or visit the MAU at any time without an appointment. Staff at the MAU could refer them, for example, to specialist advice, a scan or for an induced birth.

The staff reported that increased activity in the MAU had resulted in increased demand for induction and higher numbers of births on the labour ward. There had been a high percentage of emergency caesareans (18%-22% each month) and elective caesareans (26%-33% each month) in the year April 2017 to March 2018. Of 5679 births in that year, 84% took place on the unit, compared with 13% on B5 and 1.4% at home. Less than 2% of births took place at the standalone midwife led units. The maternity clinical scorecard showed that the average induction rate was 28% for the year, consistently above the target of 25%.

When women contacted the labour line, the ‘bleep holder’ advised if there was sufficient capacity and staffing to support a home or midwife led birth, if that was their plan. The service’s ability to staff the midwife led birth centres was dependent on activity at the obstetric unit. The location of birth was therefore influenced by capacity and staffing.

Some staff reported they did not feel able to promote birth choices at the standalone centres, or at home, as they knew staff might not be available due to demand pressures at the hospital. They said it was easier to flex staff to support births at the alongside midwifery unit (B5), at Queen Alexandra Hospital, than at the other midwife led units in the community. This meant women might not be able to have their planned place of birth.
The service had carried out a birth choices survey in the past year, which showed approximately a third of women were not satisfied they received support with their birth choices, with about half of these commenting they did not achieve the birth they had hoped for.

The Maternity Matters report 2017, compiled by Wessex Voices and local Healthwatch for four NHS trusts including Portsmouth, showed that 23% of people in Portsmouth said that birth place options were not discussed with them. The report cited two comments from Portsmouth mothers: “Was warned that my preference of St Mary’s midwife led would be unlikely due to staffing. This needs rectifying, it should be a real option if women would like to use it” and “[birth options were] briefly mentioned. I was directed to use an app”.

The service had developed a schedule for antenatal appointments, based on the needs and past obstetric history of the woman. If women did not attend appointments, there was a policy and procedure for midwives to follow, to minimise the risks associated with non-attendance.

**Learning from complaints and concerns**

**Summary of complaints**

From January 2017 to December 2017 there were 31 complaints about maternity services (5% of total complaints received by the trust). The trust took an average of 32 working days to investigate and close complaints; this is slightly longer than the time set out in their complaints policy which states all complaints should be closed within 30 working days. Clinical treatment was the main subject of complaint with 65% of complaints relating to this. The table below shows a breakdown of complaints by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>20</td>
</tr>
<tr>
<td>Admission, discharge &amp; transfer</td>
<td>4</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>4</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Access to Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Patient privacy / dignity</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Complaints)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

Staff were aware of the types of complaints received and understood how to support people with concerns or formal complaints. The complaints leaflets summarised the process and included information on how to seek advocacy if required. Staff said they offered women a debriefing opportunity postnatally, and an opportunity for reflection.

There had been two complaints in October 2017 relating to perineal suturing. The service had carried out a thematic review and created a ‘lessons learnt’ poster for suturing, as well as suturing workshops, to improve practices.
Is the service well-led?

Leadership

There had been recent appointments to leadership roles in the service. Leadership roles and arrangements were not yet embedded but staff felt better supported.

The trust’s medical director was the executive lead for maternity and the maternity safety champion, supported by the chief nurse, in line with Better Births recommendations.

Staff reported that the new head of midwifery was visible and approachable, and they welcomed their open door approach to leadership. They were also positive about the midwife in charge role and the ward leadership arrangements.

Hospital maternity unit staff said had seen members of the board executive team and considered the team were engaged and responsive. Staff had found the update on trust-wide developments helpful and were aware of the planned restructure of the trust and consultation process.

There had been inconsistent leadership in the community which has impacted on staff morale. The unit had recently appointed staff to provide leadership and support for the community teams which staff appreciated.

The trust recognised issues with the medical leadership of the service and clinical engagement. It had invited the Royal College of Obstetricians and Gynaecologists to review leadership and culture. This had taken place two months before our inspection.

Vision and strategy

The service was in the process of developing and agreeing its vision and strategy with key stakeholders, including the wider health economy and women’s representatives.

The service was part of the SHIP (Southampton, Hampshire, Ilse of Wight and Portsmouth) Local Maternity System (LMS). The LMS had submitted its strategy, based on the Better Births 2016 national guidance, to the NHSE for review. This included work streams to deliver the Better Births project, with a focus on the personalisation of maternity services and improving outcomes. The plan included implementing the ATAIN work programme later in 2018, to reduce avoidable harms, and a project to reduce smoking in pregnancy. The SHIP network aimed to develop and single point of access to their maternity service, supported by a new, unified IT system. Within the Portsmouth maternity services,

A new trust strategy was still in development at the time of the inspection, and maternity services were working on aligning a local strategy with that of the LMS, referencing local demographic data and population surveys.

Culture

The service recognised there was a need to improve the culture in some areas of the service and had initiated an external review of medical engagement. Most staff recommended the service as a place to work, and they were supported to take their breaks.

Staff told us there was a positive culture for learning and development. However, there was a view that morale had been influenced in the past year by staffing difficulties. Community midwives felt demoralised and the integrated model of working meant they had lost a sense of teamwork. Some also commented on being placed in situations where they felt vulnerable.
The last staff survey in 2017 showed that 19% of staff reported bullying and harassment from their manager and 26% of staff reported bullying and harassment from colleagues. In 2016, the service started the staff-led RESPECT group, to identify and address negative behaviours. Whilst we were on the inspection, we observed staff were very considerate towards each other and demonstrated compassion, care and teamwork.

The trust board had begun implementation of a trust-wide culture change programme during 2018, having recognised this was an area for development.

The trust had recently committed to the Royal College of Midwives ‘Caring for You’ initiative to support staff and create a compassionate workplace. The service had adopted the NHS model for training professional midwifery advocates, midwifery advocates and advocates, and had started to roll out training.

The trust had refreshed its ‘Freedom to Speak Up’ campaign, and had an appointed Guardian, and a team of advocates to support staff. Staff were aware of the Guardian and had received advice on their role.

Staff were proud of the quality of care they provided. They had created information boards to display complaints, plaudits, recommendations and ‘you said, we did’ feedback, for women and visitors to view.

**Governance**

The service had recently revised its governance arrangements to reflect guidance on safer maternity care, and some of the new governance committees and accountabilities were relatively new. The service recognised it needed to improve its approach to audit, reporting and improvement to support good governance.

At Portsmouth Hospitals, the maternity board was a subgroup of the trust executive board and provided a support and scrutiny function. The quarterly maternity board meetings were co-chaired by the director of midwifery and the chief nurse and its terms of reference were agreed in March 2018. Minutes showed this was an effective meeting, with the risk register, performance, feedback and complaints as some of the standing items for the agenda. The chief nurse was an appointed maternity safety champion.

**Management of risk, issues and performance**

The trust had initiated systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. These were not fully effective, as there was a lack of assurance that learning was embedded.

The trust had created a safety improvement plan 2017-2020 based on the recommendations of a range of publications, including the National Maternity Review, Better Births 2016, Saving Babies Lives Care Bundle and the National Maternity Safety Strategy 2017. The women and children’s clinical service centre (W&C CSC) governance and quality committee monitored the maternity improvement plan. The W&C CSC governance and quality committee met each month and the terms of reference for the committee were ratified in April 2018.

The service had a risk register but it did not capture all the risks of not meeting the maternity safety improvement plan. There were three items on the maternity risk register, which was reviewed, updated and presented at the quarterly maternity board meetings:

- the maternity IT system, as their main IT system was no longer supported and this presented a risk to information sharing and security,
- the use of a white board in the hospital, which presented an information governance issue, and
- the risk of losing part of the B5 unit to the main trust.

Staff were aware of these risks, but did not actively contribute to the register.

The monthly maternity clinical effectiveness and safety committee monitored the risk register, the activity of the 11 clinical PODs, training, and oversaw the completion of the maternity services safety improvement plan. The PODs were obstetrician-led teams of senior midwives and junior doctors, with a remit to review and update the clinical effectiveness of their area. There were PODs, for example, for maternal medicine including obesity; screening, infectious diseases and fetal medicine; antenatal care; diabetes; theatres, bereavement. The PODs reported to the maternity safety review group and to the clinical effectiveness and safety committee. The clinical effectiveness and safety committee submitted action logs to the W&C CSC governance meeting.

Staff reported that the PODs varied in their value, with some being more effective than others. This was an area the service planned to improve.

The clinical audit process was not robust. There was a newly appointed clinical governance lead for the service. The audit plan for 2017/18 showed that only a quarter of the audits in the 2017/18 plan had been completed. The audit action tracker highlighted 72% of the 65 completed audits had outstanding action plans to complete. Seven audits had passed their proposed start date without being registered (e.g. use of MEOWS chart for post-operative women in maternity). It was not clear how audit findings were used and not all completed audits reported on the risks identified.

Senior managers acknowledged that the audit programme needed enhanced ownership through the PODs. The service recognised and told us they needed to review their audit programme and ensure they identified and shared lessons effectively. They also recognised they needed to undertake regular, meaningful, safety audits. This was an item for the May 2018 clinical effectiveness quality and safety committee meeting.

The service met with commissioners to review performance, activities, concerns and opportunities on a quarterly basis. Maternity services produced a clinical scorecard, which was a clinically focused report of monthly safety and performance data.

Staff said they did not have regular meetings but they were informed of safety updates and issues through the safety huddle, when they worked at the hospital. Community staff said they tried to hold meetings locally, but it was difficult to get staff together. We found that not all staff were aware of action plans relating to recent incidents.

We found that learning from previous incidents and root cause analyses was not shared effectively. For example, one root cause analysis action plan stated that individualised care plans should be written in detail in the hand held notes, however we found examples where this had not been actioned.

**Information management**

The maternity IT system did not support comprehensive recording and analysis of data.

This was on the service risk register, as the system was no longer supported by the IT provider. Staff reported it was not suitable for producing reports. For example, the unit had difficulty assessing the reasons for foetal abnormalities. We were told the service could not set up their IT system to require staff to fully document blood loss during post-partum haemorrhaging, which meant they could not fully audit and analyse the safety risk. The service had developed workarounds to report on minimum data sets, to offset the shortcomings of the IT system.
During our inspection, we were told the monies had been approved to replace the current IT system with one compatible with the other organisations in the local maternity system (LMS), for improved information sharing and security.

Staff reported they wasted time inputting data and searching for information due to the complexity of the records process.

**Engagement**

The trust engaged well with women, staff the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service worked effectively with Maternity Voices to capture the views of women as part of the LMS project to deliver the Better Births agenda. There was good engagement between the organisations. The service also asked for direct feedback from women and families, using the Friends and Families forms.

In 2017, maternity services, Local Healthwatch and Wessex Voices surveyed women and their partners in Portsmouth, Southampton, Isle of Wight and Hampshire (SHIP), about their maternity care. They captured the views of 1200 people. Although Wessex Voices found women had very positive experiences throughout their pregnancy, they acknowledged areas of improvement and made recommendations for improving pregnancy services in the future.

Wessex Voices assisted in gathering the views of people in different equality groups and worked with the services to design surveys to help support their strategic planning. The local maternity voices champion met with women who would not necessarily access feedback systems and shared this information to help improve services. The service also took account of the CQC maternity survey, which had prompted a reminder to staff to introduce themselves by name.

In the 2017 staff survey, maternity services scored worse than the rest of the organisation and the comparator group for:

- ‘I am involved in deciding on changes introduced that affect my work area/team/department’,
- ‘I am able to make improvements happen in my area of work’,
- ‘I am able to meet the all the conflicting demands on my time at work’ and
- ‘There are enough staff for me to do my job properly’.

It also scored worse for reporting harassment or bullying. Since this survey, the service had recruited to some of the vacancies and continued the recruitment programme and initiated projects to improve engagement. It performed better than other services in the trust for reporting incidents, receiving feedback and knowing that action is taken is a result. It also performed well for training and development and responding to concerns raised by patients.

The trust had invited the RCOG to work with the service to improve the engagement of medical staff, as this had been highlighted of an area for development.

**Learning, continuous improvement and innovation**

The service had good systems for training staff and was working towards providing improved arrangements for sharing learning:

The service had improved access to the maternity assessment unit by making it available 24/7. This had enabled maternity to increase the surveillance and screening services and reduce the stillbirth rates.
The local maternity system (LMS) planned to develop a training academy across the local health economy. Portsmouth’s maternity service had 11 PODs which reviewed guidelines, audits, education, research and investigations. The service acknowledged further work was required to make these more effective.

The service had supported the development of apps and websites to inform women about their services and about options for care. For example, the 'my maternity' app and the 'My Birthplace' app. The Emotional Maternal Wellbeing website supported perinatal mental health signposting for women.

Staff said the elective caesarean section pathway, provided by maternity support workers, had helped improve patient experience for those having a planned birth by caesarean section. They also said that being in the first wave of the maternity neonatal and safety collaborative project meant they had access to best practice and innovation in other services which had been useful.

The service had also planned to take forward some quality improvement projects in community midwife led units, antenatal clinic provision and the CORAL service.
Services for children and young people

Facts and data about this service

The trust provides paediatric care to a population of approximately 100,000 children. The trust has 84 inpatient paediatric and Neonatal Intensive Care Unit (NICU) beds on one site (Queen Alexandra hospital):

- Children’s assessment unit (CAU) – 15 care spaces (11 beds and 4 trolleys).
- A7 (Starfish) – 24 beds.
- A8 (Shipwreck) – nine inpatient beds and nine day surgery beds.
- Neonatal Intensive Care Unit (NICU) - Level three tertiary referral units with 31 cots of which there are 14 level 1 cots, 4 level 2 cots and 13 special care cots.

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 5,989 spells from December 2016 to November 2017.

Emergency activity accounted for 85% of spells (5,077 spells), 14% of spells (829) were day case, and the remaining 1% (83 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from December 2016 to November 2017, Portsmouth Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Alexandra Hospital</td>
<td>5,988</td>
</tr>
<tr>
<td>This trust</td>
<td>5,988</td>
</tr>
<tr>
<td>England total</td>
<td>1,099,209</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

The neonatal unit provided a community neonatal nursing service to babies discharged from the unit and have continuing care in the community needs.

Children and young people are also cared for in other areas of the hospital for example theatres, adult outpatients, critical care and the emergency department.

We also spoke with the research team, children’s safeguarding team, some nurse specialists and a dietician.

Patients, and parents or carers, can access paediatric specialist services via their GP, the Emergency Department and other healthcare professionals (HCP) e.g. midwives. There is also
open access for an identified group of chronic patients who have direct access to the ward using their ‘Yellow Card.

During our inspection, we spoke with 62 members of staff including doctors, nurses, allied health professionals, play therapists, administration, domestic staff and teachers. We also spoke with the directorate leadership team and 15 children and parents. We reviewed 18 patient records and many pieces of equipment.

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of all mandatory training modules, aside from information governance, which was set a target of 95%.

In services for children and young people, medical and dental staff met the target with 85% compliance.

A breakdown of compliance for mandatory courses for medical and dental staff from April 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>55</td>
<td>55</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>55</td>
<td>55</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>55</td>
<td>55</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>55</td>
<td>55</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>55</td>
<td>55</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>51</td>
<td>53</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>52</td>
<td>55</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>52</td>
<td>55</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>50</td>
<td>55</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>15</td>
<td>18</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>44</td>
<td>55</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>30</td>
<td>38</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>40</td>
<td>55</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>35</td>
<td>55</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Specialty Specific Fire Safety</td>
<td>8</td>
<td>18</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff met the target in nine of the 16 training modules, achieving 100% compliance in five modules. Staff failed to meet the 85% target in eight modules including adult basic life support where 44 of 55 eligible staff had completed training.

The reason compliance with the above modules were not met were due to maternity leave and long-term sickness. The trust also did not provide us with a full year of data.

Qualified nursing staff met the mandatory training target with 94% compliance overall.

A breakdown of compliance for mandatory courses for nursing staff from April 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Reporting</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>148</td>
<td>149</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>150</td>
<td>152</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>166</td>
<td>171</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>166</td>
<td>171</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>161</td>
<td>171</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>65</td>
<td>70</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>128</td>
<td>141</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Specialty Specific Fire Safety</td>
<td>72</td>
<td>82</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>71</td>
<td>81</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>130</td>
<td>152</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>80</td>
<td>152</td>
<td>53%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 3 years</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,363</strong></td>
<td><strong>2,519</strong></td>
<td><strong>94%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>
Qualified nursing staff met the target in 16 of the 18 training modules, achieving 100% compliance in six modules. Staff failed to meet the 85% target in two modules – conflict resolution and fire safety 3 years.

(Source: Trust Provider Information Request P14)

Staff we spoke with reported they completed mandatory training yearly and delivery of mandatory training was both face-to-face and online. Managers and the practice educator had oversight of the training using the development and learning database. This provided assurance managers were monitoring completion rates.

We saw evidence of a structured induction programme all staff completed when they commenced employment, which included mandatory training. Listed in the above tables is the training included. Nurses we spoke with described the induction as helpful and reported it covered use of equipment, unit orientation, fire evacuation procedures, and safeguarding and emergency contact telephone numbers. Mandatory training was primarily face to face with simulation sessions. Staff we spoke with commented the mandatory training system was good and told us they found the two-day pre-booked annual study days helpful.

Staff received an email reminder when training was due and used the trust’s electronic staff database to maintain compliance with training. A practice educator on the unit was responsible for setting mandatory training days. Staff discussed expired training reminders with managers to ensure they were compliant with the above topics.

The practice educator for the neonatal unit (NNU) kept an up to date spreadsheet showing the compliance of each individual staff member for mandatory training. Apart from seven staff, which were either on maternity leave or on long-term sick leave, all staff were appropriately updated.

Medical trainee induction was mandatory and protected which meant time was set aside specifically for trainees to complete their training. Senior house officers, GP trainees and military trainees had protected induction with time available for mandatory training.

Staff we spoke with were aware of the sepsis policy and training sessions were embedded within the paediatric life support two-day course. Staff told us they received communication of sepsis awareness by frequent emails from the trust including the signs of sepsis and actions to take when staff suspected a child was suffering from sepsis.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so.

Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of safeguarding training. In services for children and young people medical and dental staff met the target with 88% compliance overall.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for medical and dental staff is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>49</td>
<td>49</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>55</td>
<td>55</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>46</td>
<td>55</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>26</td>
<td>40</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>176</td>
<td>199</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical and dental staff met the target for two of the four safeguarding modules with 100% compliance in the two modules. Staff failed to meet the 85% target for level 2 and 3 safeguarding children.

Qualified nursing staff met the safeguarding training target with 98% compliance overall.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>151</td>
<td>151</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>142</td>
<td>153</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>635</td>
<td>646</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff met the target for all four safeguarding modules with 100% compliance three out of the four modules.

(Source: Trust Provider Information Request P18)

From January 2017 to December 2017, the children’s unit made 642 referrals due to safeguarding concerns and 153 referrals for children and young people with mental health concerns. This demonstrated an understanding amongst staff about how to and what concerns should be referred.

In March 2014, the Royal College of Paediatrics and Child Health published the Safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document. The document defines the level of child safeguarding training that is required for various staff groups. The trust policy stated, in line with this document, all staff working in children and young peoples’ (CYP) services should receive children’s safeguarding training as appropriate to their role as part of their mandatory training programme.

All staff working in the CYP area were trained to level 3 which is in line with the recommendations of the intercollegiate document however, current figures showed the NNU unit were achieving 82%
compliance with level three training and paediatrics were at 87% compliance. The low compliance was due to long-term sickness and the new rotation of doctors not being immediately booked on to training.

The trust had recently introduced integrated adult and children safeguarding committees and staff we spoke with felt the new executive team valued the importance of a robust safeguarding team and had invested to increase the team to include a Head of Safeguarding with responsibility for both adults and children. All specialists and Named Professionals as well as the Head of Safeguarding were trained to Level 4 which is over and above the requirements set out in the intercollegiate document.

A named nurse, midwife and doctor for safeguarding children and young adults were available for assessment and advice to ensure the trust fulfilled its safeguarding legal obligations. The NNU had access to all Named Professionals and specialists. The named professionals offered supervision to the nursing staff upon request but also ran regular supervision sessions for the band 6 and 7 nurses or staff on the children’s unit. This ensured support and supervision was available as part of staff development.

The Safeguarding Children Team has one member who is registered with the Home Office to deliver Prevent training and another who is working towards this. Prevent is part of the UK’s Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity.

The safeguarding team were working with the orthopaedic outpatient department to review their internal processes of identifying looked after children (LAC), to ensure all relevant health professionals involved with the child were informed of changes in health needs.

Safeguarding processes were robust. An electronic system highlighted children who may be on a child protection plan or was a LAC upon admission. Nurses across the children’s unit could access this information, which mitigated the risk of staff being unaware of concerns around the family. The safeguarding team had a single point of contact, which ensured easy access to the team during working hours.

Staff we spoke with were familiar with and knew how to access the trust’s safeguarding policy. They were aware of procedures to follow and their own responsibilities if they had safeguarding concerns. Safeguarding policies and procedures were clear and staff we spoke with showed a comprehensive understanding of safeguarding issues for example, female genital mutilation and child sexual exploitation (CSE).

The safeguarding team told us they were rolling out a CSE assessment tool which was embedded in the level three safeguarding training, and included in their ‘flash mob training’ which was available as drop in sessions. Between January 2017 and December 2017, the unit made 19 CSE referrals.

Safeguarding was included in all assessments on the children’s unit and NNU. Records contained nursing assessment sheets placed at the front of the records for ease of access, and any disclosures communicated to the safeguarding named nurse within working hours or to the multi-agency safeguarding hub (MASH) outside of hours.

We saw that during handovers on both units, medical and nursing staff routinely discussed safeguarding concerns.
Staff told us they had recently attended a level three supplementary training session of the difference between baby bruising and birthmarks. Staff could define triggers that would alert them to call for safeguarding assessments and were clear about whom to contact if they needed to escalate safeguarding concerns.

In the NNU, senior nurses received safeguarding supervision and the neonatal consultants were compliant with the 2014 Royal College of Paediatric and child health (RCPCH) standards for safeguarding.

During the inspection, we saw evidence of up to date policies and processes for absconding and abduction of children and physical intervention holding policy. The trust was in the process of updating the ‘was not brought’ policy to follow up children who did not attend appointments, a flow chart and an information leaflet for parents.

The safeguarding team met recently with health visitors and school nurses to discuss children that are vulnerable and a cause for concern. The team decided to reinstate these meetings to discuss liaison paperwork and improving communication within the community.

The trust had a specific CYP chaperone policy, which was currently under review. Staff did not report receiving any chaperone training but the policy states it was at the line manager’s discretion to ensure staff were aware of a chaperone’s role.

We observed patient’s full names were visible to both staff and the public on the white boards, which was a breach of patient confidentiality as well as a safeguarding risk if parents did not want their child’s whereabouts known.

Any child or young person who presented with self-harm or medicines overdose received an automatic referral to the Child and Adolescent Mental Health Services (CAMHS). Children and young people were not discharged until the CAMHS team had completed a full review.

The children’s ward used agency mental health nurses to provide one to one care for children and young people who were waiting for tier four placements into specific mental health placements.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.9 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

The above survey is the most recent survey undertaken by the CQC.

We reviewed both units including dirty utility rooms and treatment rooms and found both units were visibly clean. We saw hand sanitiser gels were available throughout the children’s unit. All hand sanitiser gel dispensers were out of reach of small children as a safety precaution and there were red handwashing and sanitisation notices on the doors to each of the clinical bays and side wards.

Prominent signage to inform visitors to use hand sanitisers was highly visible and we observed staff asking or reminding visitors including other staff to wash their hands.

Across both units, there was easy access to personal protective equipment (PPE) such as aprons and gloves and we witnessed staff using PPE effectively.
We observed staff adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting the unit and clinical areas. Staff told us they felt confident to challenge staff to ensure they were ‘bare below the elbows’ and used PPE such as gloves and aprons.

Parents we spoke with on the NNU told us staff ensured high compliance to hand washing and we observed all staff were bare below the elbow. All areas of NNU were visibly clean and the mothers we spoke with were highly satisfied with the level of cleanliness within all aspects of the NNU and told us the domestic staff kept the unit spotlessly clean.

There were sufficient amounts of side rooms across the unit to isolate patients who were at risk of spreading infections. Signs outside the side rooms alerted staff and visitors of infection transmission risks, and advised the use of aprons and gloves where appropriate.

Infection, prevention and control (IPC) was part of mandatory training and the children’s unit had appointed a dedicated IPC link nurse. The clinical staff knew who their link nurse was and reported a good flow of communication about IPC issues such as regular hand hygiene audit results. The IPC standard operating procedures and policies we reviewed were up to date and accessible on the hospital intranet. This assured us both units were following local procedures to prevent the spread of infections.

Audits of IPC compliance were completed monthly and briefing sessions with updates on audit results discussed in the nursing handovers. Noticeboards throughout both units communicated to staff and visitors the results of monthly audits such as hand hygiene, which displayed high rates of compliance.

The children’s outpatient’s department provided a separate waiting area for patients with low immunity and susceptible to infection. We observed this to be good practice.

We observed staff would clean all equipment and the patient areas after discharge. Both units had an area for storing cleaned machinery and a green tag displayed the date and time of cleaning. Therefore, the unit was taking steps to prevent the spread of infection.

We inspected many items of equipment such as commodes, electronic thermometers, weighing scales and infusion pumps and found a good level of cleanliness with visible up to date “I am clean” stickers.

The play team identified all toys were washable and told us toys that had been with a child or young person with a known infection were deep cleaned after use.

Waste management and removal, including those for contaminated and hazardous waste was in line with national standards.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The children’s ward was a safe environment and featured a child friendly theme with a mobile interactive floor projection system. The Children’s unit had a large outside play area as well as inside play areas and the children’s outpatients had a dedicated play area within the waiting room.

There was a receptionist on duty who would allow access to the unit during the hours of 8 am to 5 pm. Monday to Friday. Outside these hours, access to the unit would be via the main reception that held a list of inpatients. To aid security, closed circuit television covered all exit points. Staff were aware of the importance of checking the identification of all visitors entering the unit and visible signs on the main entrance doors reminded families to be aware of tailgating.
Both the units were part of a recent Private Finance initiative (PFI) which offered large and spacious clinical accommodation. The NNU offered tertiary neonatal intensive care, high and special care to pre-term, sick term babies born in and around Portsmouth, the Wessex region, and further afield. The unit is part of a regional network of neonatal intensive care units, which make up the Thames Valley and Wessex Neonatal Operational Delivery Network.

Within the NNU, we saw electronic access doors with full CCTV coverage controlled by the ward clerk and nurses. We saw there was a current abscondment policy, which included ‘lockdown’ procedures in the case of a baby going missing in the unit. However, a pre-rehearsed systematic approach to abduction had not been undertaken.

Tailgating in to the NNU was strictly monitored and enforced. We saw individuals challenged when attempting to tailgate into the unit. Access to the neighbouring maternity department, was accessed through electronic coded doors.

In the theatre department, there was a child friendly waiting room and a dedicated recovery bay of five beds. All theatre equipment was appropriate for use with children and young people. This followed recommendation from the Guidelines for the Provision of Anaesthetic Services (GPAS) 2016. We observed a risk assessment had been undertaken for instances where the children’s recovery bay is used for adult inpatients. It ensured children were not exposed to adults and we were told this occurrence rarely happened.

There were two paediatric outpatient clinic-waiting areas, with consulting rooms and facilities for a range of specialities including fracture clinic and ophthalmology. There was a designated waiting area for teenagers.

There was a paediatric radiology suite (x-ray and ultrasound) within the paediatric unit. All areas including changing rooms and waiting areas were appropriately decorated and child friendly.

In both units, all rooms dangerous to children such as the treatment room or the cleaner’s cupboard were secured with a keypad or key. However, the sluice door was not lockable but did have a high handle and cupboards containing cleaning materials such as detergent tablets were unlocked. This posed a risk for unauthorised children and young people to access these areas. We raised this concern with staff at the time of inspection.

Both milk kitchen doors on the children’s unit were not lockable. This posed a risk of unauthorised access and possible deliberate contamination of breast milk, which was stored in the fridge. The fridges and freezers in both milk kitchens were not lockable.

Where possible, accommodation of patients with autistic diagnosis, sensory, behavioural or mental health needs was in a cubicle. This ensured the safety and wellbeing of children with additional needs.

In CAU, the resuscitation areas were clean, well-stocked and clinical guidance and protocols were accessible and clear.

The units were well equipped with equipment such as syringe drivers and intravenous pumps. An equipment specialist oversaw the ordering, repair of equipment, and ensured it was charged and quality tested before use.

Bins for the safe disposal of sharps were available in secure areas. We observed sharps bins correctly labelled with a date of opening and signed as per trust policy. None were filled above the maximum fill line.
The children’s ward was a safe environment and detailed door slam protection to protect children’s fingers and all rooms had high handle access. Hot drinks brought on to the ward required to have a cup with a lid to prevent spillages.

Across the children’s unit, we saw resuscitation trolleys and equipment were in accessible locations. We observed all resuscitation trolleys to be stocked correctly, checked every day, and emergency equipment was charged and fit for purpose. We saw evidence staff in children’s outpatients checked the resuscitation trolley weekly due to low usage and all resuscitation trolleys were secured with plastic snap locks, and medicines observed to be in date.

We observed the NNU corridors were free of clutter and the resuscitation trolleys secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. Staff checked the trolleys daily and weekly with staff signing a log. Consumables and equipment in the NNU were appropriately stored and labelled and the paediatric cardiac arrest box was secure and dated.

Mothers in the NNU could breast fed their babies with good degrees of privacy which did not compromise baby safety.

**Assessing and responding to patient risk**

Assessment of risks to children, young people and families were assessed, monitored and managed appropriately.

In the CQC Children and Young People’s Survey 2016, the trust scored 7.8 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016, the trust scored 9.7 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The management of sepsis was clear, robust and consistent with national guidance.

Staff on both units completed observation charts, which included a version (which met with the relevant standards) of the paediatric or neonatal early warning system (PEWS and NEWS). The PEWS or NEWS scores were age specific and used to monitor babies and children to ensure early signs of deterioration or sepsis was recognised.

We saw evidence staff consistently recorded PEWS and NEWS scores alongside the vital signs and documentation we reviewed demonstrated appropriate actions taken when required.

Neonatologists on the NNU told us all staff complied with neonatal standards of care, neonatal polices and participated in the National Neonatal Audit programme (NNAP). Additionally, the unit followed British Association of Perinatal Medicine (BAPM) neonatal guidelines such as the Neonatal Service Quality Indicators: Standards relating to structures and processes supporting quality and patient safety in Neonatal Services and guidelines provided by the Thames Valley and Wessex Neonatal Operational Delivery Network.

Staff monitored babies in the NNU for signs of deterioration using neonatal observation charts, which measured key physiological parameters such as respiratory rate, oxygen saturations, blood pressure, heart rate, temperature, and level of consciousness and documentation we reviewed demonstrated appropriate actions taken when required.
The unit provided monthly if capacity allowed, impromptu children’s simulation sessions for the multidisciplinary team to improve the management of patients with specific clinical conditions, for example patients with a respiratory condition or sepsis. Staff received constructive feedback regarding their performance and reflected it was a positive exercise with good opportunities for learning in a safe environment.

The children’s ward regularly cared for children and young people who had self-harmed or had other mental health issues. The mental health team liaised closely with the children’s team to ensure the correct care and supervision provided kept the young person safe. A referral system was in place for the children and adolescent mental health service (CAHMS). Out of hours, the adult mental health team would review CYP.

If a violent or aggressive incident were to occur, staff would call for assistance from the security team, and after the incident the safeguarding team would lead a debrief. This ensured staff had support in relation to keeping themselves and their patients safe.

For children requiring surgery, we observed staff completing pre-operative safety checklists. We also observed the World Health Organisation (WHO) ‘5 steps to safer surgery’ checklist was completed which reduces risks associated with surgery. We observed staff used the PEWS tool post operatively to identify any early deterioration in the child’s condition.

The children’s assessment unit had two resuscitation rooms, one for a baby and one for an older child, which had clear protocols and staff used a Safe Transfer of the Paediatric Patient (STOPP) tool to determine the safest transfer arrangements for children who required transfer to a specialist unit or within the trust. Children would stay in the resuscitation room to await retrieval by specialist retrieval teams.

The adult critical care unit could offer care for young people using either the critical care staff, as there were sufficient numbers of dual qualified nurses or staff from the children’s ward. The children’s medical team would care for the children whilst they were on the critical care unit.

Staff across the children’s unit completed daily and weekly checklists to ensure the safe running of the wards. These included emergency trolley checks, environmental checks and controlled medicine checks. However, we observed during inspection the weekly checklist had not been completed but previous weeks were complete. We inspected midweek.

We saw across the units Local Safety Standards for Invasive Procedures (LocSIPPS) where used when NG tubes were inserted. This followed the National Safety Standards for Invasive Procedures (NatSIPPs) which support the NHS to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur.

**Nurse staffing**

The neonatal unit did not have enough nursing staff with the right qualifications, skills, training and experience, which might affect the ability to keep people safe from avoidable harm and abuse and to provide the right care and treatment, although we did not observe any evidence.

The trust has reported their staffing numbers below for qualified nursing staff from April 2017 to December 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE actual in post</th>
<th>WTE planned staff</th>
<th>Fill rate</th>
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<tbody>
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Fill rates ranged from 87.7% to 95.3% during the period. As of December 2017, there were 12.28 fewer WTE staff in post than the trust planned to provide safe and effective care.
<table>
<thead>
<tr>
<th>Month</th>
<th>Planned</th>
<th>Actual</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>148.4</td>
<td>166.9</td>
<td>88.9%</td>
</tr>
<tr>
<td>May</td>
<td>146.3</td>
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<td>87.7%</td>
</tr>
<tr>
<td>June</td>
<td>145.9</td>
<td>166.0</td>
<td>87.9%</td>
</tr>
<tr>
<td>July</td>
<td>147.5</td>
<td>165.5</td>
<td>89.1%</td>
</tr>
<tr>
<td>August</td>
<td>150.0</td>
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<tr>
<td>September</td>
<td>152.9</td>
<td>160.4</td>
<td>95.3%</td>
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<tr>
<td>October</td>
<td>151.9</td>
<td>166.1</td>
<td>91.5%</td>
</tr>
<tr>
<td>November</td>
<td>154.8</td>
<td>166.1</td>
<td>93.2%</td>
</tr>
<tr>
<td>December</td>
<td>153.8</td>
<td>166.1</td>
<td>92.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Return (RPIR) – P16 Total numbers – Planned vs actual)

The NNU had staff qualified in speciality (QIS) and all had advanced life support skills. The title ‘QIS’ applies only to those nurses who have achieved a qualification by completing a programme of study that matches the quality standards developed by Health Education England and the British Association of Perinatal Medicine (BAPM). The NNU aspires to fund up to six nurses per year to undertake this programme at the local university. However, there was a shortage of QIS nurses within the unit, which failed to comply with BAPM standards. The senior management team reported there was a long-term plan in place to recruit more NNU nurses.

Leads from the NNU were fully aware of the BAPM requirements for staffing for the NNU and were aware the unit was not compliant with these standards and the issue detailed on the NNU risk register.

We inspected the Badger net online resource, which is a paperless reporting maternity system used within NNU across the UK and facilitates real-time recording of events. We randomly selected dates from the Badger database and examined the staffing levels for day and night duty. There were two dates out of five shifts, which exceeded the prescribed, BAPM staffing levels. Staff on NNU reported they always met the one nurse to two babies’ criteria but if one to one care was required, the nursing rota could be flexible to meet demands.

Staff told us to reduce risks caused by lower staffing levels the unit used bank staff or matched staff allocation to the degree of acuity of individual babies within the level three neonatal intensive care unit. Staff told us there was minimal use of agency staff and they were happy with the staffing numbers and although they were busy, it never compromised the care provided.

There were 80 whole time equivalent qualified nurses and 17 unqualified working across the children’s unit.

It was identified the children’s unit did not have a formal tool to assess the acuity of patients and required staffing levels. RCN guidance states ‘there should be a ratio of one nurse to three patients for children under the age of two years, a ratio of one to four for patients over the age of two years, during the day and night shifts, and an experienced band 6 should be on duty over the full 24-hour period’. The guidance also stated, ‘the standard for a general inpatient ward should reflect the age of the child as well as acuity. Hospitals should therefore use a proven methodology to assess acuity of patient care that clearly reflects the needs of children, not adults’.

Nursing staffing levels and skill mix were planned using national guidance with contingencies for staff to work flexibly across the service as required. In the absence of any formal validated acuity/dependence tool for children staff told us they used their professional judgement. However, staff told us they were aware of the need for an acuity tool and were looking at using a national recognised acuity tool to adapt and use on the unit.
Electronic rotas were reviewed on the children’s unit and staffing levels were as planned providing the minimum 70:30 ratio of qualified to unqualified staff. We saw evidence in the last two months each shift had the required number of registered children’s nurses with the correct advanced life support skills.

There was band six or seven senior nurse cover for 24 hours a day over a seven-day week on the children’s ward. Depending on staffing levels, the band six or seven would be supernumerary and be available to support the other areas of the unit if required.

Shipwreck’s current model of staffing was for five qualified staff in the morning and four in the afternoon with two qualified at night. Due to an increase in overnight admissions, the matron developed a business case for three nurses overnight. CAU planned was four qualified in the day, three qualified at night, and they are trialling a band three nursery nurse to cover a twilight shift. Starfish ward was five trained in the morning and five trained in the afternoon with four trained overnight. Additionally, they had two nursery nurses each shift.

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017, the trust reported an annual vacancy rate of 8.9% for qualified nursing staff in services for children and young people.

The trust did not supply a target vacancy rate but qualified nursing staff in this core service had a higher vacancy rate than the trust total for all staff groups of 7.3%.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

At the time of inspection, there were no vacant nursing posts on the children’s unit. The NNU were actively recruiting.

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

In December 2017, the trust reported a turnover rate of 8.0% for qualified nursing staff in services for children and young people, which is better than the trust’s turnover target rate of 10.0%.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported an annual sickness rate of 3.4% for qualified nursing staff in services for children and young people, which is worse than the trust’s target sickness rate of 3.0%.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format, we will be able to populate the analysis to complete this section.

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*
Staff on the children’s unit reported they no longer used agency staff, existing staff would work additional hours and the ward used NHS Professional (NHSP) bank nurses. Staff reported most bank nurses were familiar with how the unit ran.

NHSP booking figures between January 2017 and December 2017 for CAU were 10 qualified and 4 unqualified, both wards were 645 qualified and 97 unqualified and the neonatal unit was 842 qualified and 138 unqualified. All staff we spoke with voiced concerns about staffing particularly during busy periods.

**Medical staffing**

The children’s unit did not have enough medical staff with the right qualifications, skills, training and experience, which might affect the ability to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The trust has reported their staffing numbers below for medical and dental staff from April 2017 to December 2017.

Fill rates ranged from 95.7% to 105.4% during the period. As of December 2017, the service had an over-establishment of staff with 2.73 more WTE staff in post than planned to provide safe and effective care. However, at the time of inspection this number had decreased leaving a shortfall of medical staff.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE actual in post</th>
<th>WTE planned staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>50.8</td>
<td>51.7</td>
<td>98.3%</td>
</tr>
<tr>
<td>May</td>
<td>50.2</td>
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<tr>
<td>June</td>
<td>49.5</td>
<td>51.7</td>
<td>95.7%</td>
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<tr>
<td>July</td>
<td>49.5</td>
<td>51.7</td>
<td>95.7%</td>
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<tr>
<td>August</td>
<td>50.7</td>
<td>51.7</td>
<td>98.1%</td>
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<tr>
<td>September</td>
<td>54.5</td>
<td>51.7</td>
<td>105.4%</td>
</tr>
<tr>
<td>October</td>
<td>52.6</td>
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<td>101.9%</td>
</tr>
<tr>
<td>November</td>
<td>53.6</td>
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<td>103.9%</td>
</tr>
<tr>
<td>December</td>
<td>54.4</td>
<td>51.7</td>
<td>105.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Return (RPIR) – P16 Total numbers – Planned vs actual)

The children’s unit had 15 whole time equivalent consultants and 15 remaining medical staff across the unit.

The consultant figures were compliant against the RCPCH recommendations but the registrar figures were not. Two regular locum registrars covered gaps in the medical rota or existing staff covered.

Consultant and trainee rota gaps were a significant issue across the units. There was a clear drive to fill the rota gaps internally with consultants acting down and internal locums. External locums were minimised and when used, there was a strong preference to cover gaps with staff that had worked in the trust before. Despite this mitigation, there remained a significant rota gap amongst consultant, senior and junior trainees.

Consultants on the NNU we spoke with told us potential risks to babies caused by a reduction in specialist registrar allocation from the deanery were mitigated by concentrating consultant activity on clinical work and not, despite being important other non-clinical areas of duty. There was 24-hour consultant cover for the neonatal unit seven days a week.
Additionally, the neonatal unit employed Advanced Neonatal Nurse Practitioners (ANNP) who worked as part of the medical rota. One of the ANNP's and a junior doctor we spoke with told us the doctor/ANNP system worked well.

The medical handover, within the paediatric unit, took place at 08:30 - 09:00 am during weekdays and 09:00 am during weekends, afternoon handover at 3 pm and night handover at 9 pm. There was a dedicated period in the handover to highlight issues including; risk patients, isolation cautions, incidents, elective patients and any other issues.

We observed the consultant to be clinically supportive of the junior doctors. Junior doctors told us they received good support from their seniors and felt able to approach them for advice.

On both children’s wards surgical and orthopaedic doctors supported children’s surgical patients, with children’s paediatrician support as needed. The duty consultant was the named children’s paediatrician for surgical patients.

The children’s unit had two hot week consultants who covered from Friday at 08.30 am until the following Friday 08:30 am. One consultant covered shipwreck ward and CAU and the other covered Starfish ward but would help across the service when required. Overnight there was one registrar and one senior house officer who covered the children’s unit from 21.00 pm until 09.30 am in addition there was a Duty Consultant on-call from 17:00 pm to 09:00 am.

CAU had access to the opinion of a children’s consultant 24 hours a day.

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017, the trust reported an annual over-establishment of 1.7% for medical and dental staff in services for children and young people with more staff in post than there were budgeted posts.

The trust did not supply a target vacancy rate but medical and dental staff in this core service had a lower vacancy rate than the trust total for all staff groups of 7.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

There were seven full time equivalent consultant neonatologists with plans to increase this to eight.

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

In December 2017, the trust reported a turnover rate of 3.1% for medical and dental staff in services for children and young people, which is better than the trust's turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
From December 2016 to November 2017, the trust reported an annual sickness rate of 1.6% for medical and dental staff in services for children and young people, which is better than the trust’s target sickness rate of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Locum usage between January 2017 and December 2017 is 12 consultant shifts, 28 doctors in training and two middle grades.

Staffing skill mix

In October 2017, the proportion of consultant staff and of junior (foundation year 1-2) staff reported to be working at the trust was about the same as the England average.

Staffing skill mix for the 50 whole time equivalent staff working in children’s services at Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>53%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of children and young people’s care and treatment. Records were clear, up-to-date and available to all staff providing care.

Paper records were standardised across the units and were multidisciplinary. There were assessment and care plans for specific care pathways. The care records covered relevant assessments of care needs, risk assessments and were patient centred and personalised. Included within the records was a daily evaluation of whether the patient’s health and emotional needs had been met.
We noted in eight out of 10 records we reviewed on the children’s wards that the activities of daily living were not complete. When discussed with parents they reported they would have been keen for a nurse to explore their child’s normal routines.

Records we reviewed highlighted documented evidence staff focused on ensuring patient and parental understanding and involvement. The records showed daily reviews by consultants with the date and time with clear management plans.

The admission sheet placed at the front of the notes, detailed any safeguarding risks, name of GP, health visitor and social worker. It also detailed the patient’s school or nursery. All admission sheets reviewed were fully completed. These helped to ensure all staff could easily identify safeguarding risks. This information enabled staff to communicate with the GP’s or health visitors where necessary.

We observed records in the children’s unit to be stored securely in a lockable notes trolley. However, we observed the trolley was always unlocked, but positioned in a central area where there was always a member of staff around.

Within the NNU, we saw medical records were securely stored at all times in a lockable cabinet. When the cabinet was open for example during ward rounds, the cabinet was adjacent to the ward receptionist.

Access to electronic records was password protected and accessed by individual swipe cards. Computers we observed during the inspection were locked, password protected, and we observed them to time out so the screens locked if they were unattended. We observed one instance where a doctor left the screen open. We raised this with a member of the nursing team who reminded the individual to sign out of the screen.

We reviewed 18 sets of medical notes and found these were legible, signed and dated. Paper records were standardised across the units and were multidisciplinary.

Nurses and the administration staff reported notes were easily accessible and it was a rare occurrence not to have the notes available for surgery or clinic.

**Medicines**

Overall the service prescribed, gave, recorded and stored medicines well. However, we found some expired medicines on the children’s ward had not been disposed of in a timely way.

Medicines and controlled medicines (CD’s) were securely stored with key operated locks for cupboards and medicine fridges across both units.

Staff monitored fridges storing medicines temperatures and recorded temperatures daily. However, we found concerns with the records on some wards. For example, we saw on Starfish ward, the fridge for chemotherapy storage did not have a thermometer that could read minimum and maximum temperatures. This did not provide assurance the chemotherapy medicines were kept at optimal temperatures.

We spot-checked the expiry dates of medicines, including open liquid medicines and found within Starfish ward nine oral medicines were past their opening dates or did not state the date of opening. We noted three bags of intravenous fluids were expired and some intravenous (IV) fluids were stored in boxes on the floor. Therefore, we had no assurance staff on starfish ward had a robust process of rotating and checking expiry dates on items. We raised these concerns at the time of inspection, out of date medicines were disposed of correctly in line with their medicines policy, and the boxes of IV fluids removed from the floor.
We checked the storage of medicines, including controlled drugs on the NNU. Staff managed and stored medicines securely, within the treatment room, which was secured with a coded lock, with all medicines kept in locked cupboards. Pharmacy staff replenished and managed stock and staff reported no issues with supply. Ward staff checked controlled drugs daily and pharmacy audited medicines quarterly. Controlled drug (CD) stationery was secure and stock and records were accurate.

We observed staff checking controlled medicines and staff reported the process for reporting missing CD’s was as per the trust protocol.

Across both unit’s staff consistently completed medicines charts with the child or baby’s allergies, weights and the person prescribing clearly identified. Nursing staff checked all medication against the date, time, patient and correct dose. Upon review of 18 medicines charts, all medication was administered on time.

Both units had their own pharmacy team who provided clinical advice, support to patients, training and medicines supply. There were systems in place to reduce delays with medicines for patients to take home with them. These included near patient dispensing points, occasional use of FP10 prescriptions and discharge planning which included the pharmacy team. The children’s assessment unit (CAU) held a stock of pre-labelled to take home medications.

Staff learnt from medicine incidents by discussing medicine incidents that have occurred in the medicines mandatory training days as a reflection exercise. Staff we spoke with described the reflections as very useful learning.

One nurse had received funding from the trust following attending the trust innovation panel to develop a prototype key finder which would cut down the amount of time trying to locate medicine cupboard keys and ensure medications were given in a timely manner.

Incidents

The service managed patient safety incidents well and responded appropriately to significant events.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported no incidents which were classified as a never event for services for children and young people.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in services for children and young people, which met the reporting criteria, set by NHS England from February 2017 to January 2018.

This was a diagnostic incident including delay meeting SI criteria (including failure to act on test results).

(Source: Strategic Executive Information System (STEIS))

Learning from the above diagnostic incident included medical staff signing blood gas results to provide evidence the result had been reviewed and acted upon if required.
All staff across both units could describe how incidents were reported using the Datix system and how online reports were subsequently addressed and lessons learned. Staff were aware of how to report incidents and could access the online system. Staff were encouraged to report incidents and were able to identify types of situations that should trigger incident-reporting completion, including ‘near miss’s situations. Staff told us they received feedback when they reported incidents.

Staff could describe learning and actions taken from incidents, for example a patient’s intravenous cannula site had not been checked which resulted in extravasation of the cannula site. Extravasation is the accidental leakage of certain medicines into the body from a drip into the vein. Learning taken from this incident was to use a window technique when bandaging the cannula site. An introduction of a cannula site checklist served as a reminder to check the site hourly.

Another example of learning from incidents was where a parent found a patient handover sheet. Learning from this incident resulted in handover sheets printed on bright yellow paper to ensure they were highly visible. This provided assurance actions and learning from incidents occurred to mitigate further risks.

The children’s unit discussed incident investigations at the monthly Friday Lunch information Meeting (FLIM) that was open to all across both units to attend.

The NNU discussed incidents in the twice-daily huddles, which coincided with nursing handovers, and included the maternity department team. Huddles were short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical staff, opportunities to understand what was going on with each patient, and anticipate future risks to improve patient safety and care.

Discussion of incidents happened at the formal multidisciplinary mortality and morbidity meetings and staff reported incidents were also discussed during handovers. Information relating to incidents was cascaded to the woman and children’s board via the monthly neonatal governance meetings. Risks were discussed in the paediatric management and governance meetings.

The duty of candour (DoC) is a regulatory duty relating to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of the DoC and, senior staff we spoke with were clear about their responsibilities in relation to the DoC and confirmed it was part of their mandatory annual training.

The trust reported in the RPIR, senior staff had received training in root cause analysis. However, senior staff we spoke with reported they had not received training. Training would be useful for improving the way staff conducted investigations into incidents to ensure a robust investigating process.

We observed National safety alerts displayed in the clean utility areas where medicines were prepared, discussed at the monthly governance and FLIM meetings and sent out to staff by email.

### Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from December 2016 to December 2017 for children’s services.

(Source: NHS Digital)

The service was using a safety thermometer designed for use with adult services and adapted for children. The service was not using the NHS children and young people national tool. Therefore, the tool was not in line with current guidance and did not give the appropriate snap shot of safety within the children’s unit. However, the matron reported the unit used a paediatric trigger tool, where results demonstrated no harm had been caused across the paediatric unit.

The Paediatric Trigger Tool (PTT) is a structured case note review tool that measures the rate of harm (adverse events) in the organisation using paediatric-specific triggers to identify adverse events. It provides paediatric teams with an unbiased measure of the incidence of harm experienced by their patients (i.e., harm caused by medical care).

Is the service effective?

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Delivery of care pathways for neonates was in line with referenced national clinical guidance and staff accessed policies and procedures via the trust intranet.

We saw both units had access to the online Paediatric Innovation, Education and Research (PIER) Network policies and procedures website. Other NHS trusts across the region had established and contributed to PIER. This comprehensive on-line resource provided evidence based protocols for neonatal and paediatric care delivery, which underpin multi-professional care and facilitates shared best practice and the development of regional guidelines and original research.

The trust had systems and processes in place to monitor compliance with National Institute of Clinical Excellence (NICE) guidelines. Policies, quality standards and guidelines were discussed in governance meetings led by a paediatric consultant and changes or updates were linked to the PIER network. This ensured all policies and guidelines were up to date and in line with the Royal College of Paediatricians and Child Health, (RCPCH) and NICE guidelines. However, we reviewed trust policies including diabetic ketoacidosis 0-19 years, abduction policy and early onset of sepsis and found the early onset of sepsis was three months out of date for being due for a review. However, the trust provided evidence that both the NNU and children’s unit were compliant with most NICE guidelines.

The trust intranet hosted a full range of polices pertinent to the care of neonates and children and staff we spoke with found the system easy to access via their computers. However, staff reported there was a policy in place for the transfer of a critically ill child, but one member of staff was unable to locate a paper copy or a copy on the trusts intranet. This did not assure us policies were easily accessible.
The trust had developed care pathways for the management of children presenting at the trust with specific conditions. This ensured a consistent approach to their management and it was in line with NICE guidance. We saw examples of pathways for febrile convulsions and bronchiolitis. The Neonatal unit (NNU) developed pathways following the NICE guidance for antibiotics and jaundice.

We saw evidence the children’s unit achieved 100% compliance with NICE clinical guideline 50, which makes evidence, based recommendations on the recognition and management of the acutely ill patient in hospital which demonstrated assurance staff were skilled at recognising the deteriorating child.

At the last inspection in June 2015, there was some conflicting information in different documents in relation to the management of paediatric diabetic ketoacidosis (DKA). We saw evidence during this inspection there was one policy for the whole of the paediatric department.

Multidisciplinary staff presented findings and recommendations from audits at the monthly FLIM meetings and circulated presentations via email. This ensured staff were updated with changes in practice resulting from audits.

The trusts critical care unit followed best practice protocols for the care of children and young people. They worked in close liaison with another NHS trusts critical care unit and shared protocols for continuity in the case of transfers.

The neonatal unit was preparing for accreditation by UNICEF (United Nations International Children's Emergency Fund) to ensure implementation of Baby Friendly standards for all new mothers. Baby Friendly accreditation is a nationally recognised mark of quality care for babies and mothers. The NNU were preparing to achieve the level one standard, which aimed to support mothers to breastfeed and help all parents to build a close and loving relationship with their baby irrespective of feeding method.

In 2016, the NNU became the second unit in the United Kingdom to gain accreditation for its family-centred care under the Bliss Baby Charter (for babies born premature or sick). Bliss is a charity, which supports volunteers to enter neonatal units and support parents of ill or premature babies. The Bliss Baby Charter is an accreditation scheme, which measures against seven standards, which identify the level of family centred care provision within a unit.

The neonatal network had completed a recent external audit of the NNU and they were awaiting the outcome so actions for improvement could be undertaken.

Nursing handovers, we observed across the units routinely referred to the psychological and emotional needs of patients, as well as their relatives and carers.

Following an introduction of a new team in the emergency department to assess children who had self-harmed the number of self-harm admissions to the children’s unit had reduced. Additionally, the documentation group was developing a pathway for children and young people who self-harm.

All children and young people displaying severe depression or a first episode of psychosis received referral to the Child and Adolescent Mental Health Services (CAMHS) and seen on either the same day as the referral or the day after.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. We saw the promotion of breast-feeding throughout the NNU in a non-discriminatory way and staff supported mothers irrespective of their feeding method choice. The mothers of very sick neonates...
requiring intensive care were encouraged to express their milk and breast pumps were freely available.

The NNU had appointed a family support team, which consisted of seven members of staff who were breast milk advocates. The team provided feeding support at the cot side and on discharge. If parents wished, they could hire electric breast pumps via their local Sure Start children’s centre.

We examined the fridges and freezers where breast milk was stored within the milk room in the NNU. The fridges and freezers were fully compliant with storage standards and we saw evidence staff monitored temperatures daily. We examined the stored breast milk and found all bottles correctly labelled, dated and stored correctly.

However, within the children’s unit we found freezers containing breast milk included ice pops. This posed an infection risk due to food items being stored with bodily fluids.

The NNU provided resident parents with meals and the parent’s kitchen had a microwave oven, fridge, kettle and toaster to facilitate meal preparation for non-resident parents.

Children could request the meals they like. There was a three-week rolling menu with an appropriate range of choices. Religious and cultural dietary needs were accommodated. If long-term patients did not like the food offered the kitchen would be able to cook them food of their choice. One child had left feedback of “the dinner ladies are nice and friendly”.

The activities of daily living document enabled staff to ask children and their parents or carers about eating and drinking preferences, appetite and ability to feed. For infants this included what milk was normally consumed, how much and how often. However, it was noted in eight out of ten records this was not completed.

There was dietetic support for both units and a diabetic nurse specialist to support diabetic patients.

Every child had a height and weight completed and the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) was available in the paediatric ward pack. However, the 18 notes we reviewed did not have the assessment completed. The National Service Framework for Children and Young People recommends that a nutritional assessment is undertaken on every patient and this leads to a nutrition plan.

Children were encouraged to eat dinner together around a table, which promoted nutritional needs and encouraged children to eat.

**Pain relief**

The service managed children’s pain effectively and staff administered and prescribed medicine in a timely manner.

The NNU managed pain relief well. There were effective processes in place to meet babies’ pain relief needs such as non-nutritive sucking and kangaroo care, in which the baby and carer achieve skin-to-skin contact.

Acute pain management guidelines were available to staff and there was access to the acute pain team if support was required across both units.

We reviewed completed children’s pain assessment charts in the nursing care plans and saw staff reviewed the child’s pain relief for effectiveness and made changes if necessary.
We observed staff discussed pain relief with children and/or their families. Staff used a visual pain assessment chart such as smiley faces and gave parents an information leaflet about pain relief at home (after surgery).

Children undergoing surgery were prescribed pain relief by the associated team in anticipation of the surgery to ensure children were pain free postoperatively. We observed the surgeon discuss pain and pain relief with a parent before going to theatre.

Medicine records showed clear prescribing of pain relief with the time, route and dose of the medicines administered.

We observed staff and play therapists used numerous distraction therapies and techniques throughout the children’s services to help reduce the children’s pain and distract them from painful procedures. Play specialists were available to assist the medical and nursing teams, as required.

The children’s unit used local anaesthetic cream and cold spray for children to reduce the pain from invasive medical procedures such as venepuncture.

We observed excellent distraction techniques as well as calming interactions with parents during three children undergoing blood tests.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows in the 2015/16 diabetes audit Queen Alexandra Hospital performed similar to the England average.

The proportion of patients receiving all key care processes annually was 33.8%, which was within the expected range, compared to the national aggregate of 35.5%. The previous year’s score was 16.1%.

The average HbA1c value (adjusted by case-mix) at the trust was 66.9 which was within the expected range, compared to a national aggregate of 68.3. The previous year’s score was also within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 64.0, which was not significantly different to the previous year’s median of 64.0.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

From September 2016 to August 2017 there were no patients under the age of one readmitted following an elective admission. For patients aged 1-17 years old 0.6% of ENT elective patients were readmitted within two days of discharge, which was the same as the England average 0.6%.
Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Portsmouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>ENT</td>
<td>0.6%</td>
<td>1,234</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from September 2016 to August 2017, 2.7% of patients under one were readmitted within two days following an emergency admission to general paediatrics, which was similar to the England average of 3.3%.

For patients aged 1-17 years old the trust performed similar to the England average for emergency readmission rates following an emergency admission to general paediatrics and colorectal surgery. The trust performed worse than the England average for general surgery with 8.1% of patients being readmitted following an emergency admission compared to the England average of 3.7%.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Portsmouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.7%</td>
<td>1,491</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Portsmouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3.1%</td>
<td>3,551</td>
</tr>
<tr>
<td>General Surgery</td>
<td>8.2%</td>
<td>122</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>4.2%</td>
<td>144</td>
</tr>
</tbody>
</table>
Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From October 2016 to September 2017, the trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma (21.0% compared to the England average of 16.4%). The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy (21.1% compared to the England average of 27.9%).

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Portsmouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>21.0%</td>
<td>124</td>
</tr>
<tr>
<td>Diabetes</td>
<td>*</td>
<td>-</td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>44</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>21.1%</td>
<td>38</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with ‘*’.

National Neonatal Audit Programme

In the 2017 National Neonatal Audit, the Queen Alexandra Hospital’s performance in the four measures relevant to services for children and young people was as follows:

- **Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5°C and 37.5°C.**

  Out of 116 eligible cases identified for inclusion, 78.1% of babies less than 32 weeks gestation that had temperature taken within an hour of admission that was between 36.5°C and 37.5°C. This was a positive outlier when compared to the national aggregate of 61%.

  The trust did not meet the audit’s recommended standard of 90% for this measure.

- **Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission.**

  Out of 428 eligible cases identified for inclusion, 99.6% had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This was a positive outlier when compared to the national aggregate of 90.5%.

  The trust did not meet the audit’s recommended standard of 100% for this measure.
- **Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity.**

  Out of the 112 eligible cases identified for inclusion, 97.5% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

  The trust did not meet the audit’s recommended standard of 100% for this measure.

- **Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age.**

  Out of the 45 eligible cases identified for inclusion, 80.0% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This was in the middle 50% of results. The national aggregate was 61.2%.

  The trust did not meet the audit’s recommended standard of 100% for this measure.

The junior doctors allocated to the NNU undertook one audit per year, for example an audit of neonatal jaundice, NICE Sepsis guidelines and hypoglycaemia. The neonatal unit also participated in benchmarking exercises, locally, nationally and internationally with the USA. Staff discussed learning from audits in the PIER and monthly FLIM meetings.

Research within the neonatal unit was robust and had a lead consultant for research. The unit participated in a range of national research projects including a Feeding and Autoimmunity in Down’s syndrome with a University and a study, which aimed to improve neonatal service delivery for babies born between 27 and 31 weeks gestation in England.

We observed audits such as the audit of babies’ admission temperatures recorded on the Badgernet online neonatal system. Badgernet is a single record of care for all babies within neonatal services across the UK.

The children and young people’s (CYP) service was regularly reviewing the effectiveness of sepsis management through local audit. Results reviewed showed effective sepsis management for children and young people across the inpatient and NNU unit.

### Competent staff

The service made sure staff were competent for their roles

All staff new to the organisation underwent a corporate induction in addition to a local induction when they joined the trust. The local induction included mandatory training and equipment, ward and medicines familiarisation over a period of six months.

A newly developed preceptorship programme for nurses included study days such as respiratory, oncology and respiratory. Opportunities were available to visit different NHS trusts which offered a good networking experience to share knowledge.

The trust supported continued professional development of its staff, including formal qualifications, practical training, and conference attendance. The practice educator on NNU told us their budget was primarily for funding qualified in speciality (QIS) courses but funds were also available for a wide range of educational activities.

Rotational posts were available for staff, which included the children’s unit, CAU, and the children’s emergency department. This ensured a well-rounded experience and staff were multi-skilled when caring for children and young people of all ages. New staff had mentors for each rotation, and would complete competency workbooks to ensure competencies were achieved.
Nursing staff we spoke with knew where to access help with revalidation and told us there was good support from their peers and managers for completing this. We saw within staff break areas and toilets staff had access to information to support continued professional development (CPD), such as information on revalidation and forthcoming CPD training days and events.

Surgeons, anaesthetists, operating department practitioners and theatre nurses had appropriate training and competencies to handle emergency surgical care of children. This assured us theatre staff had the necessary skills and knowledge to care for children during procedures and in recovery. One children’s trained nurse in theatres worked half their hours in theatres and half on Shipwreck ward. This ensured this nurse maintained their competency in children’s nursing.

There were dual adult and children trained staff in critical care that had completed children’s competency training. However, most of the time a nurse from the children’s unit with high dependency training would accompany the child to critical care.

Specialist nurses were knowledgeable about Epilepsy, Asthma, Oncology and respiratory conditions. Following the admission of children with specialist conditions, the specialist nurses could provide the ward nurses with additional education, knowledge and support.

Medical staff we spoke with reported good relationships with specialist paediatricians in other NHS trusts. This helped support staff in providing children and young people with the right care.

Upon review of patient’s notes, we noted a paediatrician had seen or discussed the child or young person’s case on the children’s ward, which were under their care before discharge was completed. This was in line with the Facing the Future Standards. The CAU had access to the opinion of a consultant paediatrician at all times and the children’s unit had a consultant of the week.

We identified adult nurses in the children’s fracture, children’s ophthalmology, ear nose and throat, and the adult’s maxi facial outpatient’s department had not completed competencies associated with children. This did not assure us adult trained nurses had the correct competencies to assess and care for children in the adult and children’s outpatient departments.

The Royal College of Nursing recommend at least one member of qualified staff on the children’s unit have an advanced paediatric life support (APLS) qualification. Staff we spoke with confirmed and we saw evidence of one member of staff on every shift with an APLS qualification.

The play specialists we spoke with received level three safeguarding, had completed their mandatory training, and invited to attend the FLIM meeting.

We saw there was an induction process and checklist for any new agency nurse employed within the neonatal unit. This provided assurance agency nurses were familiar with the NNU equipment and procedures.
Appraisal rates
From April 2017 to March 2018, 81% of staff within services for children and young people at the trust had received an appraisal, which failed to meet the trust target of 85%.
A split by staff group is detailed in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>55</td>
<td>54</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>12</td>
<td>11</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>47</td>
<td>40</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>180</td>
<td>147</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>32</td>
<td>11</td>
<td>34%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>331</td>
<td>268</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

All staff groups except qualified nursing midwifery and NHS infrastructure support staff met the 85% target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We were not inspecting the midwifery service as part of this core service.

On the NNU unit, we saw appraisals were currently 100% completed and staff we spoke with confirmed they had received an annual appraisal.

All staff we spoke with reported the appraisal system to be beneficial to their personal and professional development. Staff identified learning needs through annual appraisals and told us they were given time to undertake courses and complete training. Staff we spoke with knew where to access help with revalidation and reported good support from their peers and managers.

Multidisciplinary working
Staff of different kinds worked together as a team to benefit patients.

There was an appropriate range of multidisciplinary staff providing care and treatment to patients on the children’s unit and NNU, including children’s physiotherapists, pharmacists, dieticians, speech and language therapy, play specialists, and schoolteachers.

There was direct access to children’s physiotherapy and speech and language therapy with occupational therapy provided on request.

There was effective multi-disciplinary working between psychologists, the Child and adolescent mental health service (CAMHS) and paediatricians, however, nurses reported it could be difficult to access the correct CAMHS team due to confusion over what team the young person belonged to and were restricted in making referrals up to 10 am for a review on the same day. This could delay discharges and result in the child or young person remaining on the ward for longer than required.

Consultants told us if a child requiring surgery also had medical concerns, a joint review with the surgical team would occur. Consultants worked within the range of their professional competence and reported good support by colleagues within their networks.
An administration team produced clinic letters, answered telephone calls, and arranged appointments to support the clinical teams. They would attend nursing handovers to ensure they were up to date with changes to children’s conditions and circumstances.

Discharge letters with information regarding the child or young person’s admission were shared with GP’s via email or by post but health visitors, school nurses and midwives were only sent information if requested by the medical or nursing team. This did not promote multidisciplinary team working additionally the children’s ward had information on their monthly lessons learned update to “copy discharge summaries to professionals involved in the child’s care”.

The safeguarding lead for children reported good multidisciplinary/interagency working when dealing with safeguarding issues. This ensured effective communication and sharing of safeguarding procedures.

The play team helped children to understand their condition, medical treatment and provided preparation and support for potentially stressful experiences such as medical or surgical procedures. The play team was available Monday to Friday only.

Both units’ staff reported they worked very well with the community children’s nurses, Children’s Outreach Assessment, and Support Team (COAST) nurses who were employed by a different NHS trust.

There was a very effective multidisciplinary team (MDT) working environment within the NNU and all staff we spoke with were especially complimentary about multidisciplinary working. At handovers, we observed good evidence of effective multidisciplinary relationships supporting babies and their parent’s health and wellbeing.

The NNU employed a psychological counsellor who was available once per week to see mothers who had self-referred or had been referred by staff members.

Staff reported the NNU had good links with the perinatal health professional that specialised in maternal mental health conditions, and could refer mothers to these professionals when there was a concern with their mental health. They also reported good links with the adult learning disability nurse for parents who had learning disabilities.

There was an effective transitional programme for young people with cystic fibrosis and we saw evidence the team managed their transition into adult services effectively following a ‘ready, steady go’ transition pathway where young people and their family were introduced to the concept of transition. Outpatients run a young person’s clinic week twice a year for two days to allow young people from eleven years of age upwards in dedicated clinics to prepare and support their transition journey. We saw feedback from the clinics have been positive.

Effective multidisciplinary team working was evident and we reviewed a policy for the transition of children to adult services, which addressed the medical, psychological and educational or vocational needs of the young person and their parents or carers.

Both units had 24-hour access to paediatric pharmacy advice.

Ward rounds on the children’s unit were multidisciplinary and happened before the morning handover and at 3pm.
Seven-day services

The neonatal, CAU and children’s wards were open 24 hours a day, seven days per week and medical and nursing staff provided care. The outpatient unit and day surgery beds were open Monday to Friday only.

There was 24-hour medical cover with medical presence over the weekend seven days a week on both units with access to a paediatric only radiology unit during the week and an on-call pharmacy outside normal working hours. Children’s consultant job plans covered weekends. This was in line with the RCPCH recommendations.

In winter, consultants worked 9 am to 6 pm on Saturdays and Sundays and in this time, could do a ward round and manage acute referrals. In summer, consultant weekend attendance was from 9 am to 3 pm for ward rounds both days and then on-call. This was in line with RCPCH recommendations and the current evidence on patient outcomes for summer and winter.

NNU consultants worked 8.30am to 11pm every weekday and 08.30am to 4.30pm at weekends.

Paediatric physiotherapists worked as needed on the wards, including weekends and bank holidays.

The CAMHS service operated on a 9-5 Monday to Friday basis. When children or young people with mental health concerns required admission over the weekend, they would have to wait until Monday for review for discharge by the CAMHS team. This could lead to unnecessary hospital stays.

The neonatal transport service and children’s retrieval service operated over a 24-hour period seven days a week. This service was provided by a neighbouring NHS trust.

The Paediatric Ambulatory Care Team (PACT) accepts referrals from CAU and the wards to provide intra-venous anti-biotic treatment for children who are otherwise safe to be discharged from hospital. Attendance figures are being recorded to inform service development.

Health promotion

The service effectively promoted and empowered service users to manage their own health, care and wellbeing to maximise their independence.

Within the NNU, there were leaflets on managing different health conditions, some produced by leading charities such as Bliss the UK charity for babies born premature or sick and leaflets were available in different languages. The leaflets were easy to read and written in plain English.

Staff on NNU taught all parents basic life support resuscitation on discharge and used manikin dolls to practice on.

There was significant emphasis within the NNU on informing parents on the dangers of tobacco smoke on babies’ health, the dangers of co-bedding and the importance of safe sleeping.

Within the children’s outpatient department, there was a wealth of health promotion information available for children and families. This included a topic board, which detailed a health promotion topic. Leaflets about various illnesses were available throughout the children’s unit.

Parents on both units were encouraged by the staff to care for their babies or children independently but provided support where necessary.
Children and their families living with diabetes were supported and empowered by the diabetic nurse specialists to manager their own health, care and wellbeing to maximise their independence.

A team of family support nurses on the NNU supported and empowered mothers to breast-feed their babies by offering health promotion support around the benefits of breast-feeding.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty training. In services for children and young people medical and dental staff met the target with 87% compliance overall for the four relevant training modules. Although DoLS enhanced and Mental health capacity Act Level 2 were below the trust target of 85%.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for medical and dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>52</td>
<td>55</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>52</td>
<td>55</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Enhanced</td>
<td>13</td>
<td>20</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>13</td>
<td>20</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
<td><strong>150</strong></td>
<td><strong>87%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Qualified nursing staff in services for children and young people met the target with 100% compliance overall for the four relevant training modules.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty training courses from April 2017 to January 2018 for qualified nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Enhanced</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>171</td>
<td>171</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>345</strong></td>
<td><strong>345</strong></td>
<td><strong>100%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory training)

For children under the age of 16, the young person’s decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises some children may have sufficient maturity to make some decisions for them. Staff under took a competency assessment based on the Gillick competence to ensure the child could fully understand the consent process. If staff deemed the young person not to be competent, only a person with parental responsibility was able to give the consent. However, we did not see this during inspection.
The NNU clinical staff we spoke with were knowledgeable about Fraser and Gillick competencies to help assess whether a teenage mother or a mother with learning difficulties had capacity to make their own decisions and understand the implications of those decisions. Staff told us they obtained consent from children, young people, and their parents/carers prior to commencing care or treatment. We saw an example of consent gained from parents prior to a surgical procedure. It was fully completed, signed and included information about risks and benefits of the procedure.

Staff we spoke with showed an understanding of consent and complications around children and consent. All staff described how they would ensure the child was the centre of discussion around consent and how they always gave children and young people choices when they accessed the service.

The children’s unit cared for children or young people with specialist mental health needs and the unit had access to the current Mental Capacity Act and Deprivation of Liberties policy on the intranet and staff we spoke with told us they had completed training.

The patient records we viewed included a record of parent responsibility and we observed staff enquired about parental responsibility at an early stage of the assessment process.

Parents and young people we spoke with described they were impressed how their child was included in all discussions and asked their views about their plan of care.

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed about the same as other trusts for five questions and worse than other trusts for one question relating to effectiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children’s Survey questions, effective domain, Portsmouth Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>6.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>6.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>2.5</td>
<td>Worse</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service caring?

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

Compassionate care

Staff cared for children and young people (CYP) with a great deal of compassion.

Nursing and medical staff delivered care with the upmost kindness and patience. The atmosphere on both units was calm and professional without losing warmth. We observed staff respond to call bells in a timely manner.

Parents and carers, we spoke with were overwhelmingly positive about the individual care and attention staff paid to their children and young people at the hospital.

We observed staff warmly engaging with children and their families. We saw extremely compassionate and caring interactions and staff were very skilled in talking and caring for children and young people.

Parent/carers comments included:

- “A fantastic ward whose team of nurses care impeccably for the children and the families they work with”.
- “Amazing team – really understanding of needs – the team on A7 provided the best care we could have asked for”
- “without them our babies would not be here” “- great personal support”
- “the unit is so well managed and led”

Across both units, staff received many letters of thanks. One parent whose child had an autistic diagnosis described the team as an “amazing unit with an amazing team of nurses”

During our inspection, we saw children and families of multi ethnicities, treated with dignity and respect at all times by staff. Staff respected the adolescent’s viewpoint and adolescents where possible were placed in cubicles or with their peers out of respect for their need for privacy and an acknowledgement of their growing independence and maturity.

We saw doctors and nursing staff introduce themselves to families and observed staff to draw curtains round during consultations to maintain patient dignity.

There was a strong family, child focused and caring culture across the service. We found highly motivated staff nursing babies, children, young people and their families with compassion and kindness.

We observed some exceptional staff-child interactions across the services we visited. One example was the operating department porter’s interactions with a child on the way to the operating theatre. They took their time to use humour and kindness which put the child and family at ease and resulted in the child smiling and laughing as they entered the theatre department.

We observed staff on the neonatal unit (NNU) were compassionate and welcoming to parents, which made parents feel at ease at a very stressful time.

Both units participated in the NHS Friends and Family Test (FFT), and we observed results of both units were consistently very good with most children and their carers extremely likely to recommend both units to friends and family.
We observed at times during the inspection, there were children who did not have their parents with them. We observed staff taking the time to regularly interact, reassure and play with them.

We observed several children having blood tests and observed staff to be kind, patient and compassionate towards both the child and parent/carer throughout what can be a frightening experience for the child.

All staff we spoke with across the unit demonstrated an understanding and non-judgemental attitude towards CYP who have mental health issues, learning disabilities or autism.

We spoke with nurses in the adult outpatient’s department who were very keen for children to be given a good caring experience in outpatients, although we did not observe any interactions in these departments staff were aware they could access support from the children’s unit if required.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for all ten questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, compassionate care, Portsmouth Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>6.1</td>
<td>About the same</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>8.7</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
**Emotional support**

Staff provided emotional support to CYP to minimise their distress.

**CQC Children and Young People’s Survey 2016**

The trust performed worse than other trusts for one question and about the same as other trusts for four questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, emotional support, Portsmouth Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.3</td>
<td>Worse</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.7</td>
<td>About the same</td>
</tr>
</tbody>
</table>

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

Although the above survey showed the trust scored worse than others for the privacy question, we saw privacy maintained at all times when nurses were speaking to CYP and young people we spoke with did not raise lack of privacy as a concern.

There were a range of clinical nurse specialists employed to support children and their families with the aim of reducing admissions of CYP to hospital, which would reduce the emotional harm caused to children from hospital admissions.

Psychology services were available for CYP living with long-term conditions and receiving specialist services. They were also available to assist with staff debriefs following traumatic events.

The children’s nursing team had links with the local hospice and could signpost parents and families for bereavement counselling if required.

Schoolteachers provided education to enable children to maintain a normal daily routine and by using the classroom were encouraging peer group interaction and the continued development of social skills.

We observed staff responding to both the child and family’s emotional needs in an exceptionally positive and reassuring way. Staff cared for patients with enormous compassion and the service displayed many letters and cards of thanks mentioning the emotional support provided by staff. These letters highlighted staff were dedicated to their role to meet children and their families’ emotional needs.
Mothers on the NNU were encouraged to have skin-to-skin contact to promote bonding with their babies, this also helped with lowering their heart rate, calming the baby, pain relief and parents on the NNU were positive about the family support they received.

The NNU held fortnightly parent group meetings. The topic of the meeting we attended was “helpful tips in the parent journey “and we saw there was an excellent rapport between the nurses running the group and the mothers who were attending. The group discussed a range of sensitive issues including the care of a baby who had a cognitive impairment.

Across both unit’s staff reported if a parent or child was to become distressed on the open ward staff would place the parent or child in a side room or utilise the sensory room for their privacy and dignity. The design of both units incorporated areas away from the ward environment that were specifically for family meetings or for staff to break bad news to parents.

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

**CQC Children and Young People’s Survey 2016**

The trust performed worse than other trusts for one question and about the same as other trusts for 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. There was no score for one question.

**CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Portsmouth Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Before your child had any operations or procedures, did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child's care?</td>
<td>0-15 adults</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15</td>
<td>9.3About the same</td>
<td></td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15</td>
<td>8.1About the same</td>
<td></td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td>8-15</td>
<td>9.0About the same</td>
<td></td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td>8-15</td>
<td>9.6About the same</td>
<td></td>
</tr>
<tr>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15</td>
<td>6.3About the same</td>
<td></td>
</tr>
<tr>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15</td>
<td>No scoreNo score</td>
<td></td>
</tr>
<tr>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15</td>
<td>8.7Worse</td>
<td></td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15</td>
<td>7.8About the same</td>
<td></td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15</td>
<td>7.3About the same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Transitional care services in diabetes and cystic fibrosis empowered adolescents and parents with information regarding moving into adult services and supported them emotionally to make decisions about their future care.

Parents were encouraged to be involved in the care of their babies and children as much as they felt able to. Staff encouraged parents to visit and spend time with their children and there were open visiting times in place on the children’s ward.

Parents told us staff kept them well informed throughout their child’s treatment. We observed parents were welcomed in the anaesthetic room and recovery area once the child had regained consciousness.

Children and parents, we spoke with felt they had been involved in care and decisions made around their child’s treatment. Parents and children were extremely positive about the care they received.

We observed clinicians communicate very well with and listen to, CYP and their parents. They were responsive to all questions, and asked for both the parent, and children’s views.

Parents and families told us they felt fully informed and involved in their child’s care. Parents felt in control and staff taught parents aspects of care such as nasogastric tube feeds, to support their child. Care records clearly detailed joint decisions between parents and staff. For example, a long-term patient had clear instructions regarding an aspect of their care from the parents in their multidisciplinary medical notes.

Play therapists and operating department practitioners were involved in the pre-surgical assessment. Staff used photo journey books to help explain the process to children and a photo journey for MRI scans was under development.

Parents or family members were encouraged to accompany children to surgery, from the ward and into the anaesthetic room. The recovery nurses would call the ward to bring the parents back to recovery when the child was waking up. Parents could carry the child or sit with them on the trolley back to the ward.
We spoke with five mothers who had only praise for the neonatal unit and its staff and they were very positive about their whole experience on the unit.

### Is the service responsive?

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

### Service delivery to meet the needs of local people

#### CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for all 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

#### CQC Children and Young People’s Survey 2016 questions, responsive domain, Portsmouth Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or medical needs?</td>
<td>0-15 adults</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>4.4</td>
<td>About the same</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>5.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>8-15 CYP</td>
<td>4.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>9.4</td>
<td>About the same</td>
</tr>
</tbody>
</table>
The children’s unit catered for children up to the age of 16 years old (18 years if they had long-term conditions). Children aged 16 years to 18 years could choose to go to an adult or children’s ward dependant on bed availability. When admitting 16-year to 18 year olds to an adult ward, the Head of Nursing or matron would visit the wards to ensure they were cared for in an appropriate environment. We saw evidence of a Standard Operating Procedure (SOP) for young people (Under 18 years) including those placed on a Section 5(2) requiring observation in an adult area and a SOP for admission of 16 -18 year olds to adult inpatient wards.

In 2009, the service moved from another site to the purpose-built units within the new hospital. The original plans for the paediatric unit had included a ward for teenagers and young people up to the age of 18 years. The intended ward was currently in use for gynaecological services. Discussions at senior level have occurred about moving the paediatric emergency department into the paediatric footprint to create a single point of access.

There was not a specific area in the children’s unit for adolescents although staff reported the service was looking at ways to develop this during the 2015 inspection. Staff reported adolescents were cared for in a cubicle if available or on the open bay but care was taken not to place them with other adolescents with similar problems for example mental health concerns. This resulted in some adolescents sharing bays with small babies and children.

We observed the ear nose and throat clinic had a separate child friendly waiting area for children. We observed the Max Fax clinic had nothing available for children and children would share the waiting room with adults. Children waiting alongside adults were at risk of exposure to distressing adult conversations.

During the 2015 inspection following an increase in the number of children admitted with long-term complex needs, the head of nursing was in discussion with the contracts team and commissioners to review arrangements for carers employed in the community to accompany the child into hospital to support their pastoral care. Staff we spoke with commented on how beneficial this would be for the child and family regarding continuity of care.”

Development of the paediatric ambulatory care team (PACT) occurred following an increase of the need for children to return to hospital for intravenous antibiotics and the pressure this placed on the children’s assessment unit (CAU). Their role has further developed into chasing results from the CAU and the oncology shared care NHS trusts. The development of PACT has helped reduce inpatient stays on the children’s unit.

An issue raised in the neonatal unit (NNU) by parents, was noise levels within the unit and as a response; the family support nurse had acquired an electronic ear with charitable funds, which is a noise meter, which illuminates green, yellow or red, to indicate the current level of noise. The family support nurse was moving the noise meter ear from room to room to alert staff as to the importance of noise reduction.

Within the NNU, the family support nurse coordinated a five-week baby massage course for discharged mothers and babies. The course taught new mothers full baby massage routines, which promoted bonding. Furthermore, we saw all parents on the unit could use the facilities of the hospital recreational facility including the swimming pool free of charge.

The NNU offered a community neonatal nursing service to babies and mothers who had continuing care needs to continue the support when families were discharged home.
The NNU had designed a purpose made booklet to give to parents, which detailed an insight into the care of their baby and answered questions they might have. The unit also had a large range of information leaflets for carers.

Staff had sufficient access to appropriate translation and advocacy services to support parents with language issues for example face to face interpreters or telephone interpreting as well as access to British sign language interpreters.

Following an increase in children and young people with mental health issues a child and adolescent mental health nurse (CAMHS) specialist worked in the emergency department from 9 am – 5pm. This had reduced the amount of unnecessary admissions of CYP with mental health concerns to the ward.

There were no commissioned high dependency beds (HDU) on the ward and highly dependent children were nursed around the ward. The nurse establishment includes funding to staff three HDU beds Staff reported an increase in patients requiring higher dependency care and completed audits to provide evidence and produce a business plan for a high dependency unit within the children’s unit. This was part of the Royal College of paediatric and child health (RCPCH) efforts to improve consistency and quality of high dependency unit care nationally.

Children at the end of life had purple paperwork (Advanced Care Plan) where staff recorded details of their end of life wishes. There were strong links with the local children’s hospice and the trust has access to specialist palliative care advice at regional level. The oncology specialist nurses were experienced when dealing with children at the end of life. The trust used the documentation from the child and young person’s advance care plan collaborative, which is a tool for discussing and communicating the wishes of a child, young person, parent(s) and/or their family. The plan is also designed to record the wishes of families for their baby (neonate or infant). It includes leaflets specifically designed for parents and CYP.

The outpatient cannulation and venepuncture team provided a Monday to Friday service to GP’s and the trust, as well as the research team. However, the clinic attenders had grown in size and often children would have excessive waits for their blood tests. The sister raised this as an issue with managers and they were working to develop a solution.

Visiting specialists within children’s outpatients provided clinics to meet local need and there was joint planning with another NHS trust on the delivery of services.

Throughout the trust, there was good access to WIFI to enable CYP and their families to keep in touch via social media channels.

Resident and non-resident parents in the children’s unit had use of a kitchen and sitting area, which had a microwave, fridge, dishwasher, washing machine and tumble drier. The team purchased the tumble drier following a request from a parent whose child was a long-term patient on the children’s ward.

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

The NNU provided Portsmouth “baby milestone stickers” which mothers could use to annotate their babies pictorial journey through the early weeks of life.

Across both units the “you said we did initiative “was developed to illuminate to families what actions had been taken when issues were raised. For example, on Starfish ward, parents and children had complained the cleaners woke them too early. Signs had been made and were
displayed by each bedside detailing when the cleaner would be cleaning their bed area, and do not disturb signs were used to alert the cleaners not to clean at that time. Within the NNU unit, there had been complaints about the noise levels and the family support nurse had acquired an electronic ear, which is a noise meter, which illuminated green, yellow or red, to indicate the current level of noise. The family support nurse moved from room to room to alert staff as to the importance of noise reduction.

The NNU was especially responsive to mothers with individual needs but especially those with learning disabilities and others on the autism spectrum. The nurses had access to an adult learning disability nurse specialist and parents perceived the family support service to be highly effective and efficient.

Staff placed children with sensory or learning disabilities in a cubicle if due to their additional needs they were unable to cope with the open ward environment. The play specialist was the point of contact for children with learning disabilities as well as there being a lead nurse in the trust for patients with learning disabilities.

The play team would celebrate religious festivals and encourage activities and posters to decorate the ward. This demonstrated awareness by the unit of cultural, social and religious needs.

We saw a range of information leaflets in plain English for parents across the units. These included post op advice for tonsillectomies, grommet insertion and MRI scans.

Clinic appointments were available for children with complex needs and multiple diagnoses in children’s outpatients’ clinic however; there were multidisciplinary clinics, but not multi-speciality clinics, which meant children might have to attend several different appointments on different days.

The school system on the children’s ward was extremely responsive to the children’s educational needs. The school could provide subject specific one to one tutors for older children and were able to sit their GCSE exams in hospital.

The trust offered parents visiting the NNU or children’s unit for prolonged periods discounted parking and discounted meal vouchers. The trust provided meals for mothers who were breast-feeding.

There was a gym with equipment, which young people could use and would be utilised by physiotherapists.

**Access and flow**

**Neonatal Critical Care Bed Occupancy**

From January 2017 to December 2017, the trust’s neonatal bed occupancy was higher than the England average in 10 out of the 12 months.

**Neonatal critical care bed occupancy from January 2017 to December 2017**
Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Although there is no single point of access there are pathways in place as at the time of the CQC inspection in 2015.

Self-referrals, surgery and trauma patients and children actively requiring cardio pulmonary resuscitation attend Paediatric ED. All other children referred by a health professional, medical 999 ambulances and yellow card patients attend CAU.

The senior medical team recognised and acknowledged they were outliers for the RCPCH standard of 14 hours to consultant review on the children’s unit. They felt instigating pathways and policies around certain patient subgroups, they deemed appropriate of not requiring consultant reviews less than 14 hours from admission mitigated the risks. Doctors risk assessed on an individual basis and consultants would review patients if nursing staff had concerns. We saw a snapshot audit from April 2018 of 14 sets of notes from two different weeks was undertaken. This showed 13 out 14 patients (93%) had a consultant review within 14, hours of admission (defined as when the patient was admitted onto a ward) which was an improvement on the previous audits.

We inspected the medical records of four patients on the NNU and saw a consultant appropriately saw all within 12 hours of admission. This met the RCPCH standards of 14 hours to consultant review.

There were multidisciplinary networks supporting the early discharge of children such as the community nursing team, paediatric ambulatory care team and the neonatal community nursing team.

GPs could refer children direct to the children’s assessment unit following contact with the paediatric registrar or consultant, which avoided a wait for children in the accident and emergency department. GP’s could also refer children in to urgent outpatient clinics.

A specialist advice line manned by a consultant was available for GP’s to seek clinical advice from 10:00-15:00 Monday to Thursday and 10:00-13:00 on Friday.

The service operated a “Yellow Card” policy for specific patient groups. This offered parents/carers the reassurance should the condition of their child deteriorate at any time, they could report directly back to the children’s unit without the need to go via the emergency department.

There was a clear bed capacity escalation plan to ensure optimal management when bed capacity was an issue. The escalation plan detailed all staff responsibilities when bed capacity was challenged. Staff told us beds on CAU and Shipwreck ward were used when required but this did not happen very often.

Staff in children’s outpatients monitored waiting times and messages regarding any delays displayed on the screen displaying the child’s allocated number so families were aware of waiting times.

Most theatre lists only contained children and surgeons operated on children in age order – youngest first.
Learning from complaints and concerns

Summary of complaints
From January 2017 to December 2017, there were 15 complaints about services for children and young people (2.4% of total complaints received by the trust). The trust took an average of 37 working days to investigate and close complaints; this is longer than the time set out in their complaints policy, which states all complaints should be closed within 30 working days.

Clinical treatment was the main subject of complaint with 40% of complaints relating to this, followed by attitude and behaviour (33% of all complaints). The table below shows a breakdown of complaints by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>6</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>5</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Mixed accommodation</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient delay and cancellation</td>
<td>1</td>
</tr>
<tr>
<td>Test results</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The patient information boards in each area documented formal complaints. Currently for February 2018, they were displaying no formal complaints.

There was guidance about how to raise concerns or complaints in the patient advice and liaison service information (PALS) leaflets, which were available across the units.

There was a clear pathway for staff to follow if parents raised concerns or complained, with an emphasis on face-to-face meetings to respond to and resolve issues at an early stage.

Following a complaint regarding an incident where a parent did not feel listened to about their child’s condition the children’s unit developed a leaflet called ‘what to do if you are worried about your child in hospital’. We observed these leaflets at all bedside in the children’s unit.

Children, young people, parents and carers were encouraged to complete the trust’s “elephant survey” questionnaires and there were child friendly versions to provide feedback regarding the care they received on both units.

Both units monitored complaints monthly and discussed them in the monthly governance meetings. Staff told us learning from complaints happened in the monthly Friday Lunch information meetings (FLIM) or done on an individual basis.

Staff gave us an example of a change in practice resulting from a complaint. A parent had left their child’s room and their child had vomited but the nurses had not realised the parent had left the child unattended. The nursing team put a strategy in place for awareness of when a parent was leaving and we observed staff did not leave children unattended for prolonged periods.

We attended the Patient advisory and liaison service (PALS) and spoke with one of the officers to ascertain complaints related to the neonatal unit. The PALS told us it was rare for a complaint to
be raised against the neonatal unit. For the year, 2017 to 2018 there had been two complaints one related to travel to the unit from home and the complaints were minor in nature.

Parents told us they were happy to escalate any concerns and felt staff were very responsive.

### Is the service well-led?

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

#### Leadership

There was one designated matron for paediatrics / gynaecology and one for the neonatal unit (NNU). However, the matron for paediatrics was split with gynaecology, which meant their time was not dedicated to children’s services and the matron was concerned this affected their availability to the children’s unit. However, staff we spoke with reported the matron was visible and voiced no concerns regarding her availability.

A clinical director for paediatrics was the lead paediatric consultant across the children’s unit, and there was a separate clinical director for the NICU.

The matrons were responsible for managing quality assurance and we saw evidence of strong visible clinical leadership by the matrons. The matrons reported in to the head of nursing for the clinical service centre.

Across the children’s unit, there were three band seven sisters. Staff we spoke with reported they were approachable, visible and responsive. Each sister we spoke with told us they had an open-door policy.

There was an established and stable leadership team in the NNU. Staff told us the unit’s sisters were visible, approachable, and supportive and they felt the sisters led the neonatal service well.

All staff we spoke with told us the service leadership had a good understanding of frontline challenges and we found positive and collegiate working relationships. Staff thought highly of the NNU matron and viewed them to be a highly effective leader.

Staff we spoke with were positive about the skills, knowledge and experience of their immediate managers and felt well supported.

Across both units, staff told us the leadership team were present on the wards. The head of nursing, matrons and ward managers were visible throughout the service Most senior nurses we spoke with had undertaken leadership courses to improve their leadership skills. Staff across both units told us their managers and senior nurses were supportive and approachable. Staff we spoke with were happy to approach the matron with any concerns as well as senior members of staff.

Staff across both units reported the new chief executive was maintaining a high profile within the NNU and had visited on several occasions. Both matrons told us they were optimistic about the future of the trust.

Discussions we had with the senior management teams across the service, demonstrated leaders who were patient focused and committed to improving services.

All staff knew their Matron and head of nursing and some staff were aware of members of the trust executive leadership team particularly the director of nursing and chief executive.
Staff told us the chief executive of the trust emailed weekly bulletins to update staff on hospital news. However, some staff in the NNU felt the unit did not receive much recognition within these bulletins.

The chief executive ran weekly meetings and everyone in the trust was invited to discuss wider issues surrounding the trust. This demonstrated a transparency and inclusiveness to staff from the executive team.

The nurse in charge of the shift wore a badge to make them clearly identifiable, and they had a clear role in the day-to-day leadership of the wards.

Across the unit, the children’s service had achieved gold accreditation following assessment against the trusts supervisory leadership-nursing framework three times. The service was currently waiting to see if they had achieved the platinum accreditation status.

**Vision and strategy**

The trust’s organisational priority was to be recognised as a world-class hospital, leading the field through innovative healthcare solutions, focusing on the best outcome for patients, delivered in a safe, caring and inspiring environment. Their statement of purpose is “creating the conditions to deliver the very best care for every patient”

All staff we spoke with were unable to detail the trust’s vision or strategy, although the trust’s strategy was currently four months into a six-month review following the introduction of a new executive team.

The paediatric unit’s vision was “a dedicated caring and friendly team putting children and families at the heart of everything we do”.

The trust was currently reviewing the clinical service centres (CSC’s) with a view to bringing them in to four divisions. The senior nursing team were aware of these changes but nurses at ward level were not due to the inspection occurring during the consultation process.

The service had been in consultation with commissioners who were supportive of a single pathway for admission of medical and surgical children and young people. During the 2015 inspection, plans were underway to integrate the CAU and paediatric ED services on the paediatric ED site. This had not progressed although staff, governance structures and clinical guidelines have been developed to support this integration in the future.

Most of the staff we spoke with felt well informed and supported, and were passionate about the trust values.

**Culture**

Throughout our inspection of the neonatal unit, we saw there was an inclusive and constructive working culture within the service. We found highly dedicated staff that were very positive, knowledgeable, passionate about their work, and passionate about caring for sick babies.

Clinical staff we spoke with, including doctors, nurses, and therapists consistently reported approachable and supportive colleagues and an inclusive and welcoming working environment. The staff we met told us they felt cared for, respected and listened to by their peers and managers.

The trust runs a system where junior doctors could work alongside managers to help improve services and a medical trainee we spoke with felt the department was senior led but senior staff acted upon the voice of the trainees and consultants were responsive and took safety concerns
seriously. Consultants were reactive to the change of demands of the service and provided supportive supervision to trainees.

There was a calm culture amongst the staff on the children’s unit and Starfish ward displayed a “little thought of the day” to boost morale.

The staff we met recommended the NNU as a place to work and told us as a unit it was an enjoyable and rewarding workplace, both educationally and managerially.

Staff described a ‘no blame’ culture and told us they were encouraged to report clinical incidents. There was a proactive culture in learning from incidents and sharing information and staff we spoke with could evidence the changes made as the outcome of incidences. This assured us investigation and learning from incidents was robust enough and shared effectively.

Staff we spoke with said they would be confident to raise a concern with their managers and were confident appropriate investigation measures were in place.

All staff we spoke with value the appraisal system and could evidence their learning from the reflective nature of the appraisal.

Staff we spoke with were aware of the freedom to speak up guardian and medical staff trainees all knew who their guardian of safe working was and how to exception report if needed.

Staff across the unit worked collaboratively in teams and most expressed a view they readily helped other areas when they were under pressure. However, some nursing staff expressed they were uncomfortable working in the emergency department due to a lack of knowledge. All new starters began a rotation programme through CAU, children’s emergency department, Starfish and Shipwreck wards.

Staff told us previously during the 2015 inspection, they felt the trust executive team did not address or acknowledge issues within the children and young people’s service; however, staff now reported this was changing and felt the trust showed more acknowledgement of the CYP service. The current director of nursing is the children’s champion within the executive board with a non-executive lead for children also.

Both units had a plaudit system and were encouraged to report all good news stories or positive feedback through the plaudit system, which senior staff reviewed monthly and fed back to staff through the FLIM meetings, face to face or by email.

**Governance**

The service used a systematic approach to continually improve the quality of its services.

The children’s and NNU unit sat in the women’s and children’s health clinical service centre along with maternity and gynaecology.

Both the paediatric standards and quality committee, and the CSC governance committee reported in to the Children and Young People’s Standards and Quality Committee, which reported to the board.

The Head of Nursing for the CSC is a voice for CYP from ward to board. The head of nursing sits on committees outside the trust to ensure the voice of CYP is represented in community and primary care.

The governance department met monthly and fed in to the governance working party (chaired by a paediatrician) which met monthly. The NNU and children’s unit held separate meetings. We saw
complaints and plaudits, incidences and any arising themes, lessons learnt and learning from these meetings fed into the monthly FLIM meetings to feed back to staff.

The safeguarding and the research teams attended monthly sister’s meetings. Discussion around issues arising from these meetings fed into the governance department meetings.

There was a professional nursing committee, where the matrons, head of nursing for the CSC’s and the Director of nursing attended. Issues arising from the committee were discussed in the governance meetings.

The trust had a children and young people’s board that reported to the Children and Young People’s Standards and Quality Committee. The purpose of the board was to provide an overview of the quality, associated risks and care provided to Children and Young People (0-18 years, including Maternity and Neonatal Services) within Portsmouth Hospitals NHS Trust (PHT).

The safeguarding team had recently improved their governance systems to ensure the child’s voice was heard at executive level. The integrated safeguarding operational group consisted of operation leads, representatives from the CSC’s and meetings were held every other month and fed in to the safeguarding committee which was attended by the head of nursing and chaired by the chief nurse.

Across both units at service level, there was a range of quality initiatives such as audits and parent satisfaction questionnaires to assess the effectiveness of the service. Audits included the Bliss Baby charter audit tool, sepsis audits and the diabetic audits. Discussions regarding audit outcomes and subsequent learning was shared at the FLIM meetings and disseminated throughout the wards on noticeboards and via email.

All staff we spoke with were clear about their roles and understood what and whom they were accountable to.

We saw there were standardised quality information boards across both units, which provided current quality data such as staffing levels and safety performance including medicine errors for the public to view.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coped well with both the expected and unexpected.

The trust maintained detailed risk registers, showing progress month on month. The paediatric risk register detailed a shortage of medical staff, possible sewage leak leading to potential ward closures and missed specimen reporting. Risks identified on the trust wide risk register for the children’s unit were a shortage of medical staff, consultants and juniors, a failure to achieve a financial balance and deliver cost improvement programme activity targets.

Discussions about risks on the risk register happened at the monthly governance working party and discussed further at the monthly FLIM meeting, which ensured all staff, were kept up to date. We saw evidence of risks discussed in four sets of governance minutes.

We saw evidence that winter management plans included both units with escalation plans along with the children’s wards escalation algorithm. This assured us the unit was prepared for winter pressures.

Both units used their dashboard to update the nursing and medical team through monthly team meetings, which ensured all staff were aware of areas requiring improvement. This dashboard fed up to board level to provide an oversight of both units’ performance levels.
There were mechanisms for measuring quality and escalating risks within children’s and NNU services. Members of the clinical governance team had responsibility for reviewing local guidelines to ensure they were reflective of current national guidance.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The executive board had direct line of sight from ward to board, receiving a monthly-integrated corporate dashboard, which set out performance under the domains of safe, effective, caring, well led and responsive across a range of quality metrics for each CSC.

The head of nursing for the CSC had responsibility to disseminate information up to executive level and down to staff on the front line.

There were computer stations with intranet and internet access available throughout the neonatal service and there were sufficient numbers of computers on wheels for staff to access information. Notice boards along the NNU corridors were neatly organised with information for staff and parents.

Staff we spoke with were aware of information security and knew where to report possible Information Technology (IT) breaches. All staff knew not to open unfamiliar attachments in emails and received regular reminders from the IT team regarding possible cyber-attacks.

All staff across the service we spoke with were confident in the use of the IT system to report incidents, complaints, and appraisals.

**Engagement**

The service engaged well with patients, staff, and the public to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff told us there was good communication from the trust and they felt the senior nursing team represented the NNU. Some staff did feel however, the trust had lost focus of the NNU but felt this was because they were self-sufficient.

The trust provided several communications in the form of regular newsletters and all staff emails, which highlighted local news, achievements, changes and policy updates.

Chronic Disease Groups for example diabetes and respiratory undertake local surveys for parents and CYP. Themes or changes in practice are fed through the patient experience group. The chair of the patient experience group also provides reports for trust board and the quality and performance committee.

The unit used surveys and twice a year face-to-face meetings to capture CYP and their families’ views. We saw evidence of actions taken in response, for example, a child requested to know who was in charge of the shift and the nurse in charge now wears a badge stating, ‘nurse in charge’.

A feedback ‘snake’ was available to encourage children and young people to write feedback on what they liked and what they did not like about the paediatric wards.

Both units demonstrated the ‘you said we did’ feature on their welcome boards and detailed examples of changes they had made following suggestions from parents and children. For
example, children had complained there was no dining area on the ward so staff developed a
dining area within the schoolroom.

There were regular parent meetings and surveys on the NNU and changes to facilities for parents
made as a result.

Staff told us band seven’s and the matrons asked them for ideas and there was a suggestions box
in the staff room. There were regular ward team meetings and sister’s meetings for two-way
communication.

All were encouraged to attend the FLIM meetings and there was monthly feedback to staff on
lessons learnt from incidents or plaudits.

Both units participated in the NHS Friends and Family Test (FFT), the results of which were
consistently very good, we saw all staff placed significant emphasis on the friends, and family test
and we saw posters around the unit highlighting the test.

The family support nurse on NNU told mothers about Tommy’s charity, which had launched a new
free app for parents of premature babies. It was the first of its kind in the UK. “My premature baby”
is available for mobile phones and other devices and the app contains all the prematurity
information from the Tommy's book: Having a premature baby.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when
they go wrong, promoting training, research and innovation.

An oncology shared care network for managing children with cancer supported families to have
treatment closer to their homes. It also enabled access to the best possible advice for these
families. The children’s unit was a level two paediatric oncology shared care unit.

The family support team offered parents a baby massage course, which helped parents cope with
the life changing events, which occur following the birth of a premature baby. Additionally,
students from the local college periodically came to offer hand massage to the parents.

A member of staff on the children’s unit had developed a device to locate keys remotely. Whilst it
was still under development, the device would ensure keys were located quickly to ensure timely
administration of medicines.

The NNU was actively involved in workforce development and planning for the future. For
example, some nurses were due to retire this year and active recruitment planning had
commenced to ensure staffing levels maintenance of staffing levels on the unit.

Many of the nurses on both the NNU and children’s unit had been recognised for the outstanding
contributions by both the Trust’s recognition scheme and the local newspapers celebrant events.

A band four nursery nurse has gained extensive experience in tracheostomy care and regularly
would attend the ward in their own time to update staff on tracheostomy care and assist with any
questions.

The children’s team had developed an MRI pathway for children undergoing MRI scans to ensure
it is a smooth pathway. Feedback had been very positive from the children and their carers.

The women and children clinical service centre held ‘Talent Panels’ where staff members can
request to attend to discuss their current job role and development and their career options. For
example, a nursery nurse on a band three was developed to enhance tracheostomy care (MDT)
and alongside achieving other specific competencies they were successful in achieving a
promotion to a band four. The children’s unit ran a surgical familiarisation session for preoperative
children to have a tour around the unit and the theatres in response to the CQC Children and
Young People’s Survey 2016. This helped to reduce anxiety for children and their families.
Children with long-term conditions had been to visit the blood labs to see how their blood was tested. The feedback from the children and families was extremely positive.

Staff on the children’s unit ran the ‘Bubbles’ fund which is a fundraising scheme to raise money for equipment, decorations and toys for the unit. The outside area of the children’s unit is about to undergo a complete renovation using the funds raised by staff and the public.
End of life care

Facts and data about this service

The trust provides end of life care at one of its sites, Queen Alexandra Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,166 deaths from December 2016 to November 2017. *(Source: Hospital Episode Statistics)*

Since the last inspection the hospital palliative care team and the end of life team have merged, formed one team called the hospital palliative care team. The team have been able to extend their reach and will see any adult patient for general palliative care. The team receive about 2,400 referrals a year. These include patients who were on rapid discharge and did not die in the hospital.

End of life care is provided at Queen Alexandra Hospital under the Medicine for Older People, Rehabilitation and Stroke service (MOPRS). The hospital palliative Care team provides oversight of palliative and end of life care within the hospital. It is a multi-disciplinary team of doctors and nurses. The Specialist Palliative Care Team delivers a service from Monday to Friday, 8am to 6pm. Out of hours cover is provided by a local hospice. During weekend days, there is a duty matron available for support. The ‘Hospital@Night’ team are available for patient advice. *(Source: Routine Provider Information Request (RPIR) – Context Acute)*

During this inspection we visited some inpatient wards including stroke, elderly care, general medicine, surgery, oncology and the acute medical unit. We also visited the mortuary, chapel, bereavement centre and Emergency Department (ED). We observed patient care and viewed care records where staff used the Achieving Priorities of Care (APOC) care plan. We noted the care and records of patients identified as nearing the end of their life. We spoke with patients, relatives, mortuary technicians, chaplains, porters, staff in the bereavement centre, nurses, doctors, health care assistants, paramedics, discharge team members, an occupational therapist, a physiotherapy assistant and a medical devices trainer. In total we spoke with 86 staff members. We also reviewed policies and procedures and reviewed performance information about the trust.
Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust provided mandatory training in key skills to all staff and made sure everyone completed it.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of mandatory training, with the exception of the information governance training module which has a target of 95%.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for all nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>4</td>
<td>7</td>
<td>57%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>0</td>
<td>2</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>0</td>
<td>2</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Please note that the number of eligible staff within end of life care is very low, resulting in individuals accounting for a higher proportion of the total than in other areas of the trust. On this theme, the trust only have 0.6 WTE consultant staff, therefore there is no training data for medical staff.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Mandatory training within the hospital palliative care team was mostly 100% compliant. For training not 100% complete, the percentage was skewed by the small number of staff in the team. For example 0% of staff had completed blood transfusion training but this was only 2 members of staff.

The trust had followed national guidance in providing end of life training to staff across the trust. There was an end of life e-learning module and an end of life module called ‘Setting Direction’ provided as part of induction training. More than 75% of nursing staff across the trust had completed end of life training either via induction or the e-learning module. A small number of staff had also attended a course entitled ‘My patient has died’ which was run by members of the chaplaincy and bereavement services. One of the aims of the course was to enable staff to give the best quality care to family and friends of a patient who has died. The data provided by the trust did not identify how many doctors had completed the training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for all staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Please note that the number of eligible staff within end of life care is very low, resulting in individuals accounting for a higher proportion of the total than in other areas of the trust. On this theme, the trust only have 0.6 WTE consultant staff, therefore there is no training data for medical staff.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

There was a policy in place that outlined the processes for safeguarding children and adults.

Staff had received safeguarding training and told us they were confident in recognising and reporting safeguarding concerns if required. The palliative care team told us they most commonly referred patients to social services for self-neglect. Staff told us that patients sometimes ‘opened up’ about things they wanted to ‘get off their chest’ when they were at the end of their life meaning they make disclosures that require referral to the local authority.
Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We saw very good infection control measures in the mortuary which was exceptionally clean. Staff saw infection control as a priority. Good examples of infection control practice included the availability of hand gel and the use of wipe clean keyboards for the computers. We observed an additional tap on the water fountain to routinely flush the system to reduce the risk of Legionella. There was an infection control fridge in the mortuary, which protected staff from the risk of infection from deceased patients who may have infectious diseases. There was also a designated freezer for infested bodies and bodies kept over 30 days. This was in line with national guidance. We saw there were zipped cadaver bags and a separate post mortem room for deceased persons who had notifiable diseases, to prevent the spread of infection. However, porters told us they had not received any infection control training. Even though they were aware of infection control and used PPE and special equipment to transfer deceased persons, which mitigated this risk, there was not a robust system in place to ensure all aspects of infection control training had been covered.

All areas of the hospital visited were visibly clean and we observed staff wearing personal protective equipment (PPE) where appropriate. Hand gel was available in multiple locations on all wards. We saw notices displayed on boards had been laminated to reduce the risk of cross infection. The hospital palliative care team were aware of their roles and responsibilities with regard to infection control. They wore clean uniforms and were ‘bare below the elbow’ in clinical areas.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

There were family rooms on wards (sometimes shared between wards) which provided facilities for families to have some respite if spending long periods on the ward supporting a relative at the end of life. These included comfortable chairs, magazines and complementary tea and coffee.

We saw that patients had access to the equipment they needed such as pressure relieving mattresses and syringe drivers. Staff told us there were no issues with securing these items of equipment to support patients. Equipment used in the mortuary was clean and regularly maintained. There were contingency plans for bariatric patients, including a specialist fridge and porters had received training in moving bariatric patients.

Mortuary staff were proud of the environment in which they worked and they ensured the pathway in and out of the mortuary was as seamless as possible. The mortuary fridges were electronically monitored for temperature and there was an alarm system in place to alert staff if the temperature was not in the permitted range. The mortuary staff covered a rota, which ensured the fridge temperature was monitored twenty four hours a day seven days a week.

Signage to the mortuary was appropriately discrete but clear. There were two entrances to the mortuary; one allowing un-interrupted flow from the ambulance bay (as the mortuary served as a public mortuary) and the other for the use of the hospital. The mortuary entrances were secure to prevent inappropriate access to the area. One entrance was dedicated for discharge and access to the community and was accessible twenty four hours a day seven days a week for ambulances and funeral directors. There was a ‘letter box’ which acted as a safe for valuables when the mortuary was not manned.
In total there were 139 adult spaces available in the mortuary and escalation plans for a major incident when a tent would be erected near Winchester to facilitate more mortuary spaces.

End of life patients were cared for in a side room when these were available. However, some patients chose to be on a ward to be in the company of others or in a preferred bed position in a bay.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Across the trust, there was an early warning system to identify when patients were deteriorating. Nurses were aware of how to use the tool and when to make referrals to a senior doctor. Patients were appropriately referred to the hospital palliative care team by doctors. We found patients at the end of life were monitored appropriately. Documentation in the Achieving Priorities Of Care (APOC) records showed that patients had been monitored every 2 hours, for comfort, pain, breathing, agitation, nausea, food and drink and personal care.

We saw evidence of risk assessment in care plans, these included falls risk assessment, pressure ulcer and nutritional. Patients were appropriately referred to the tissue viability nurse if appropriate and we saw evidence in patient records of tissue viability nurse input. Staff told us that pressure relieving mattresses were readily available.

We noted that staff on wards were using pink sponge swabs to provide mouth care for patients. There had been a Medicines and Healthcare products Regulatory Agency (MHRA) alert in 2012 which highlighted this as a risk to patients due to the risk of patients biting off the pink sponge and choking. However, all staff we spoke with were aware of the risk to patients and told us they risk assessed on an individual patient basis before using. This ensured patient safety.

**Nurse staffing**

The service mostly had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, nursing staff shortages meant the specialist end of life care service could not be staffed at weekends. The trust was taking action to redress this.

The Portsmouth Hospitals NHS Trust has reported staffing numbers below from May 2017 to December 2017 for nursing staff in end of life care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>7.1</td>
<td>6.4</td>
<td>90.3%</td>
</tr>
<tr>
<td>June</td>
<td>7.1</td>
<td>6.0</td>
<td>84.7%</td>
</tr>
<tr>
<td>July</td>
<td>7.1</td>
<td>6.0</td>
<td>84.7%</td>
</tr>
<tr>
<td>August</td>
<td>7.1</td>
<td>6.0</td>
<td>84.7%</td>
</tr>
<tr>
<td>September</td>
<td>7.1</td>
<td>6.0</td>
<td>84.7%</td>
</tr>
<tr>
<td>October</td>
<td>7.1</td>
<td>6.8</td>
<td>95.9%</td>
</tr>
<tr>
<td>November</td>
<td>7.1</td>
<td>6.8</td>
<td>95.9%</td>
</tr>
<tr>
<td>December</td>
<td>7.1</td>
<td>6.8</td>
<td>95.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From January 2017 to December 2017, the Portsmouth Hospitals NHS Trust reported an overall vacancy rate of 11.3% for nursing staff in end of life care. The trust has not provided an overall target for vacancy rates.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
From January 2017 to December 2017, the trust reported a turnover rate of 6.1% for nursing staff in end of life care, compared to a target of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From December 2016 to November 2017, the Portsmouth Hospitals NHS Trust reported a sickness rate of 7.9% for nursing staff in end of life care, compared to the trust target of 3.0%. This was the highest sickness rate for nursing staff in any core service. This was impacted by there being one member of staff on long term sick leave.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Two of the seven nurses in the team were on long term sick leave. This meant there was a temporary shortage of nursing staff; however, action had been taken to reduce the risk of impact on patient care. Educational tasks had been delegated to other teams and this freed up staff to focus on patients. The team had also reduced from a seven to a five day service. However, this was mitigated by the fact that nurses across the trust delivered the daily end of life care to patients. This meant that patients received a consistency of care, as daily care was provided by the same nurses. The hospital palliative care team were unable to carry out assessments at weekends and this meant a delay for some patients. However, anything urgent was referred to a local hospice for advice and support over the weekend. We did not find any evidence of impact on patient care, due to the effective planning and mitigation in place.

There was active recruitment for two and half palliative care nurses and with the return of two nurses currently on sick leave, this would lead to a return to the seven day service for patients. The hospital palliative care team did not use bank and agency nurses due to the specialist nature of the work.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The Portsmouth Hospital NHS Trust has reported staffing numbers below from May 2017 to December 2017 for medical/dental staff in end of life care.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>June</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>July</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>August</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>September</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>October</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>November</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
<tr>
<td>December</td>
<td>1.0</td>
<td>0.6</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

As the trust only had 0.6 WTE dedicated end of life care medical staff, there is no vacancy, turnover or sickness data for medical staff.

There was an end of life lead for the trust and palliative care consultant who worked across four days equating to 0.6 WTE. The trust was actively recruiting two further consultants. There were appropriate consultant cover arrangements in place with support from a local hospice when the consultant was unavailable. Senior doctors knew to contact the hospice under the service level...
agreement that was in place.

Records

Most staff kept detailed records of patients’ care and treatment. Records were mostly clear, up-to-date and easily available to all staff providing care.

We saw that patient records were locked away in cabinets with coded locks and were accessible to staff when needed.

There were some inconsistencies in patients’ records, although there was no evidence of impact on patient care. Most patients at the end of their life (in the last hours and days of life) were put on a specialised care plan called achieving priorities of care (APOC). The palliative care consultant explained that APOC was not mandatory in the trust, but was regarded as ‘best practice’ and to be used as an Aide–Memoire. This provided nursing prompts to ensure all aspects of end of life care were considered whilst leaving space for the plan to be individualised to the patient. In most cases we saw, the individualised plan had either not been completed or contained comments which were not individual to the person. For example ‘Give PRN (as required) medicine when required’ or ‘mouth care advised.’ Without the individualised part completed, the care plans appeared very task focussed. However, we found doctors notes to be more person centred and we were present at the mortality review panel where consultants commended the doctors for their records. We also found examples where doctors had not signed, printed their name, time, date or bleep number. Whilst we observed staff delivering person centred end of life care, the records did not match this person centred approach.

The APOC was used for the last days and hours of life and provided space to record three days of care. If a patient lived longer then a new APOC was required but basic information was not always transferred over to the new document. In addition the first booklet was recorded as ‘one of one’ and then a second booklet ‘two of two’. This led to confusion as the first booklet was not changed to ‘one of two’ when a second booklet was started. Therefore, it was not clear which was the current booklet.

Resuscitation decisions were recorded on a DNACPR form. We reviewed 32 DNACPR forms. We found the majority of these forms had been appropriately completed in line with national guidance published by the General Medical Council. However there was some inconsistency in identifying whether the patient had capacity and ensuring a mental capacity assessment had been completed where a lack of capacity had been identified. In five cases, notes indicated that the patient lacked capacity but there was no mental capacity assessment present on the file. It appeared that a discussion with relatives was seen as a substitute for assessing the patient’s capacity to understand the decision being made.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff followed the medicines policy and managed controlled drugs in accordance with the Controlled Drug Regulation 2013. Anticipatory end of life care medicines were appropriately prescribed. This is medicine that patients may need to make them feel comfortable but are not routinely given unless needed.

Two nurse prescribers was part of the palliative care team. They told us how they were frequently called to wards to support patients at the end of life by ‘tweaking’ medicines to make the dose more patient specific which enhanced care for individual patients.
Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The hospital palliative care team were aware of their responsibility to report incidents and told us they used the DATIX system to record incidents. Incidents were analysed and investigated where appropriate. Learning was cascaded to staff via a steering group on which Clinical Service Centre (CSC) leads sat. Staff we spoke with were not aware of learning from incidents in relation to end of life care as incidents were rarely classified as in relation to end of life care. Work was underway to extract any learning from incidents not classified as end of life but which may include elements of end of life care and share possibly via a newsletter format. There were no never events or serious incidents in relation to end of life.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported no incidents classified as never events within end of life care.

(Source: NHS Improvement - STEIS (01/02/2017 - 31/01/2018)

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from February 2017 to January 2018.

(Source: NHS Improvement - STEIS (01/02/2017 - 31/01/2018)
**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff told us they followed the five priorities of care recognised in the last days of life. We saw a ward resources file for end of life care which all staff could refer to when supporting patients at the end of life. It included ‘One chance to get it right 2014’ (leadership alliance), five priorities of care, Portsmouth specialist palliative care strategy, supportive advice for palliative care medicines and information for relatives.

During a palliative care multi-disciplinary meeting we saw that patients were assessed using Outcome Assessment and Complexity Collaborative (OACC) suite of measures. OACC is a system created to look at outcome measures for palliative care. The system assesses the phase of illness the patient is in and their current functional status. This meant the palliative care team were able to appropriately assess patients and plan any further care.

Some areas of the trust used the AMBER care bundle, a tool that helps ward staff recognise that a patient may not be responding as well as hoped to medical treatment and plan next steps. This was used when the recovery of patients was uncertain. There were plans to roll this out throughout the trust.

The Achieving Priorities of Care (APOC) care plan was used for last days and hours of life. The aim of the document was to ensure that the national five priorities of care were met for the patient. There were prompts to ensure the best care was provided and ongoing two hourly review.

Recently it had been established that the APOC did not include sufficient detail for skin care planning and therefore staff used the skin care bundle alongside the APOC to ensure appropriate care for patients with pressure ulcers or who were at risk of pressure ulcers. We found that most wards used the skin bundle.

Patient needs were assessed and care and treatment 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.

The mortuary policies were up to date, evidence based and relevant to the service they provided. Ward staff, mortuary staff and porters were aware of these policies and told us about the procedures they followed and equipment used. Standards of practice for the mortuary were based on national guidelines.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

We saw that food and fluids were monitored for patients and that appropriate care was provided for patients no longer able to eat and drink. Medical staff were aware of the General Medical Council (GMC) guidelines for nutrition and hydration in end of life care. Staff used the Malnutrition Universal Screening Tool (MUST) when they assessed patients at risk of malnutrition.
The end of life lead told us that an ‘At Risk Feeding Protocol’ was being developed by the trust to support staff caring for patients at end of life who had difficulty in swallowing. Hydration and feeding were seen as a priority in educating the whole trust.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients told us they were not in pain and we did not observe any patients in pain. Pain was regularly assessed via the APOC by both doctors and nurses with the aim that the patient was pain free. Doctors referred to the palliative care team if they required support with symptom relief. We saw that syringe driver pumps were used to give a continuous dose of pain relief. We saw that some wards used recognised pain assessment tools where patients were unable to verbalise pain, however not all wards used these.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust participated in the End of Life Care Audit: Dying in Hospital 2016. The first two metrics were above the national aggregate while the third metric was similar to the national aggregate.

- **Metric 1**: Proportion of patients for whom there was documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days (%) (Current report) (excluding sudden/unexpected deaths)
  - Trust performance 97.1%
  - England average 93.4%

- **Metric 2**: Proportion of patients for whom there was documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient (%) (Current report) (excluding sudden/unexpected deaths and recognition as likely to die)
  - Trust performance 97.0%
  - England average 94.6%

- **Metric 3**: Proportion of patients for whom there was documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care (%) (Current report) (excluding sudden/unexpected deaths and restricted LOS >24 hours)
  - Trust performance 73.4%
  - England average 73.0%

(Source: Royal College of Physicians)

At the time of our inspection the trust was fully compliant with National Audit of end of life care. The main aim of the trust was to promote holistic individualised care using a specifically designed care plan (APOC). The action plan in relation to 2017 data which has not yet been submitted will include promotion and facilitation of advanced care planning.

In March 2017, a review of the standard of the APOC on the renal unit had been completed. This demonstrated that for the most part the APOC was being used to record end of life care, however the standard of completion was variable. As a result training was provided to doctors on the renal unit regarding priorities and use of the documentation. There were also discussions with ward sisters regarding end of life and APOC training for nursing staff. There were plans to
introduce a continuation sheet for APOC to avoid confusion if key information was not transferred to a new APOC booklet. This had not been implemented at the time of the inspection.

A review of the amber care bundle was completed in January 2018. Data from this review was being analysed at the time of the inspection. The end of life lead told us that action plans would be prepared as a result.

The trust told us that work was in progress, developing a dashboard of metrics which would enable them to monitor performance in respect of fast track discharges. The aim was to ensure patients were in their preferred place of death when they died. Fast track discharge data had been collected and analysed between November 2017 and January 2018. Fast track discharge was reliant on joint working with local authorities and the data demonstrated a clear difference between two local authorities. For one local authority 58% were discharged with 0-5 days and a further 13% in 6-13 days. For the other authority 26% were discharged in 0-5 days with a further 38% in 6-13 days. New processes had been put in place to continually improve these figures.

The bereavement officer told us, patient notes were sent to the bereavement centre and they kept a record of whether Achieving Priorities of Care (APOC) had been used to record the patient’s end of life care. A summary of this was sent to the end of life lead every month.

**Competent staff**

The service made sure staff were mostly suitably trained for their roles. However, not all staff had received an annual appraisal of their work, although the trust had plans to address this.

Wards had appointed end of life champions to provide support and mentoring for staff looking after patients at the end of life. Ward staff we spoke with told us they had received specific training in end of life care, through the induction process and mandatory training.

During our inspection in 2015, we were concerned that staff had not received appropriate training in the use of the T34 syringe driver, used when supporting patients at the end of life. During this inspection the matron for medicine for older people, rehabilitation and stroke services (MOPRS) told us about a regular review of self assessment, led by the medical device trainer to ensure nurses throughout the trust were self-assessed for their syringe driver training. If they identified that further training was required, the medical devices trainer ensured the training was delivered.

During the inspection we spoke with the medical devices trainer who showed us the form staff were required to complete. Individual staff were required to sign up as competent or highlight a training need. Most nursing staff we spoke with told us they were competent in the use of the T34 syringe driver. Following the inspection the trust provided data which demonstrated that over 600 nurses had completed the T34 syringe driver training. Staff were also able to attend an IV study day. We were satisfied that the trust had addressed the concerns identified during the 2015 inspection.

Staff across the trust told us they had the opportunity to complete Sage and Thyme training. Sage and Thyme stands for Setting – Ask – Gather – Empathy – Talk – Help - You – Me – End and teaches effective communication skills to open an advanced care planning conversation. The palliative care team told us they assisted with the training.

There was a clear training program for all mortuary staff, which ensured they had the skills necessary to carry out their role. There was a bespoke training program for bereavement centre staff.

Junior doctors told us they were given a palliative care booklet as part of their induction, which gave information and guidance about managing patients in receipt of end of life care.
There was a specialist palliative care team mentorship framework for band 6 and 7 nurses. It recorded competencies and evidence of competencies achieved. This program could be developed further to define progression pathways for staff and to support revalidation.

From April 2017 to March 2018, 50% of staff within end of life care at the trust had received an appraisal which did not meet the trust target of 85%. Two staff were unable to be appraised due to sickness. Taking account of sickness the adjusted percentage was 71%. Due to the small number of staff on the team, it was difficult to achieve the target as each individual accounted for a higher proportion of the total than in other areas of the trust. Management told us they planned to complete the remaining appraisals within four weeks.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>9</td>
<td>5</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>3</td>
<td>1</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>12</td>
<td>6</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

A weekly multi-disciplinary meeting was hosted by the hospital palliative care team involving all staff needed to ensure all aspects of care for individual patients could be discussed. The meeting we attended included a palliative care consultant, a chaplain, an occupational therapist, a discharge co-ordinator and four registered nurses.

Ward staff, we spoke with, told us they had a very good relationship with the palliative care team. They reported effective multidisciplinary communication and care on wards resulting in holistic patient care.

The hospital had strong links with a local hospice, who worked closely with the palliative care consultant and the mortuary.

**Seven-day services**

The palliative care team was not able to provide a seven day service due to current staffing shortages, and difficulties recruiting two further palliative care consultants meant planned developments of the service were put on hold. However, doctors throughout the hospital were experienced in providing care to patients at the end of their life and patients were only referred to the hospital palliative care team when further specialist advice was needed from the team. This meant that the palliative care team were not actively caring for every dying patient and that palliative care was an integral part of care provided within specialities throughout the hospital.

At weekends, when the specialist palliative care team was not available, consultants and senior doctors are able to seek support from consultants at a local hospice, who worked closely with the trust. At night, the night matron on duty covered the palliative care bleep so that continuous care and support could be provided to patients at the end of their life. Staff and patients generally reported to us that timely, compassionate and effective palliative care was available around the clock.
This shared approach to end of life care combined with support from the night matron and consultants from a local hospice adequately mitigated the team’s temporary difficulties in not providing a seven day service.

**Health promotion**

Patients were provided with information about the Rowans Living Well Centre. This was a daily drop in service offering support to patients and their families who were living with a life limiting illness. It offered activities, complementary therapies, relaxation techniques and the opportunity to sit and chat.

During the inspection a joint health and wellbeing event was held by Portsmouth Hospitals and Macmillan cancer support. The event was for patients and carers in addition to the opportunity to meet their clinical nurse specialist, patients and carers were given information about keeping active, eating well and living life.

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

Staff, within palliative care, understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. However, we found inconsistencies in the use of the mental capacity act by doctors when completing DNACPR forms.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We saw that staff within the palliative care team had completed Mental Capacity Act training. Nurses, within palliative care, told us they assessed patient’s capacity upon discharge, to ensure the patient had the capacity to understand the implications of their care, the level of support they required and the appropriateness of the discharge destination.

Staff told us they sought consent from patients. We saw evidence recorded in patient notes that consent had been given for a rectal examination and a chaperone provided.

During the inspection we noted inconsistent use of the Mental Capacity Act across the trust by doctors completing DNACPR forms. There were five cases where the patient was identified as lacking capacity but a mental capacity assessment was not present on the patient’s records. We reviewed 32 forms but not all of those patients lacked capacity. It appeared that a discussion with relatives was seen as a substitute for assessing the patient’s capacity to understand the decision being made.

The trust reported that from April 2017 to January 2018, Mental Capacity Act (MCA) training level 1 and level 2 had both been completed by 100% of staff within end of life care.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Please note that the number of eligible staff within end of life care is very low, resulting in individuals accounting for a higher proportion of the total than in other areas of the trust.

The trust reported that from April 2017 to January 2018, Deprivation of Liberty Safeguards (DoLS) training at both introduction and enhanced levels had been completed by 100% of staff within end of life care.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Enhanced</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>DoLS Intro</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff caring for patients with empathy and humanity. During the inspection we found many examples of where staff had gone the extra mile to support patients and their relatives at an extremely difficult time of their life.

A staff member in ED had developed the butterfly system. This was a system whereby patients were designated with a butterfly when assessed by doctors to be at the end of their life. This ensured the dignity of the patient but also indicated to staff, without being intrusive, how to care for the patient. However, we saw that the butterfly system was used inconsistently around the hospital. We saw a patient on one ward had a butterfly displayed but staff on another ward told us they didn’t use the butterfly and they weren’t sure why it wasn’t used on their ward. The staff member in ED had gone on to develop the system allowing relatives of patients at the end of life to park without charge. The system, which had been proposed but not yet implemented, was for relatives to display a butterfly in their windscreen.

One relative had asked for their family member to stay on a ward rather than move to a side room as they liked to look out of the window and believed they could see their relative’s house from the window. Staff had respected this. The relative went on to describe how care had been “above and beyond” and staff had left “no stone unturned.” Their relative had been washed every day and likes and dislikes had been taken into consideration by staff when offering food and drink. The relative also reported that staff took time to joke and chat with her relative. We also saw a hospital pet as therapy (PAT) dog visiting a ward which was therapeutic for patients.

A relative, who had cycled to the hospital to sit with their family member, was offered the opportunity to shower and change by staff in order to make their time with their family member more comfortable. We spoke with staff who were compassionate, celebrating with a patient who was able to move to their chosen place of care. Staff were happy for the patient and described to
us how pleased they were that the patient was dressed nicely with a flower in their hair for the transfer. Ambulance staff had arrived to transfer the patient, but were asked to wait until the patient had eaten their lunch, which they did. Staff spoke about a real success story with pride that the patient’s wishes had been achieved.

Mortuary services were tailored to the need of the individual and peoples’ emotional needs were addressed. The pathway of the deceased patient had been clearly thought through and various possible scenarios were anticipated to cause the least possible distress for families. Double entry fridges were used to ensure respect to the deceased person was maintained and curtains were used in the viewing room so relatives could maintain privacy. There was an arrangement with the hospice for viewing a child’s body once all documentation had been completed rather than in the mortuary.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Families said they were well informed about the condition of their relative and found staff to be helpful and reassuring. Records showed detailed discussions with relatives regarding recognition that the patient was dying and plans of care, including regular updates, decisions about preferred place of care and advanced care planning. Relatives told us they couldn’t fault the care from all staff, they were able to spend as much time with their relative as they wished and camp beds were available for relatives if needed. Staff told us they sometimes sat with palliative patients and held their hand. They told us that if they were concerned about a patient's mental health they would refer to the mental health liaison team for specialist advice and support.

The bereavement officer met with relatives after death, to give advice about next steps, usually within 48 hours. The bereavement service provided to relatives was outstanding. The personal level of caring and discrete support which was offered to relatives was exceptional, including ensuring a calming atmosphere, with water fountains, classical music, reed diffusers and the ‘right type’ of flowers. Leaflets which supported families about next steps were simple and helpful. For example the first step was on the front page so that relatives, who were too distressed to read about actions to take after death, were able to take the first step without having to open the booklet. The service provided other support with aspects which can be distressing for a bereaved relative such as how to stop junk mail.

Bereavement staff saw offering emotional support as part of their role, “the last act of caring.” We saw examples of how staff had met with bereaved relatives and assisted with funeral arrangements. A subsidised funeral service was offered to families whose baby had died.

Staff had worked hard on improving the bereaved relatives’ journey taking steps to make it as seamless as possible. Staff were flexible ensuring an individualised approach for each family so their wishes were met. For example, staff came in on the Easter Bank Holiday to sort out paperwork for the following Tuesday to ensure a smooth flow after an extraordinary busy weekend.

Staff knew members of the chaplaincy team by name and told us chaplains frequently visited the wards. During the inspection we observed a chaplain offering emotional comfort and support to a patient and their relatives. Chaplains told us they visited wards daily to offer comfort and support. They had a list of people from different faiths they could call on to ensure that a patient’s religious wishes were met. We attended a hospital palliative care multi-disciplinary meeting at which the chaplain was present. The emotional impact on family and staff caring for a dying patient was considered for all patients.
We visited the chapel which we found to be a welcoming environment. There was a ‘request for intercessions’ book and responses written alongside by the chaplain demonstrating that they were actioned. There were cards for sale and a simple prayer for the sick written out for those who wanted to pray. The Roman Catholic chaplain told us he held a mass every Sunday at 4pm which he kept to under half an hour so that staff could attend in their break. He told us it was always well attended.

Emotional support was available for staff, through a counselling service or referral to occupational health. Staff told us they supported each other.

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

Staff involved patients and those close to them in decisions about their care and treatment.

Patients and relatives told us both doctors and nurses were good at communicating with them about the care patients were receiving. They did not feel rushed and their questions were answered in a detailed manner. We saw evidence which demonstrated that patients were involved in their own care. Conversations with relatives were clearly documented. Relatives told us they asked questions so they could understand their relative’s care and treatment. One relative told us they felt very well informed. A consultant explained everything to them and their family.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.

The trust saw end of life care as ‘core business’ and it was regarded as a priority by the executive team. The trust was the biggest provider of end of life care in the area. Statistics demonstrated that 60% of the population of Portsmouth will likely die in the hospital. Based on this information, the end of life service was seen as an important part of the trust’s core business and plans had been made to develop the team with further recruitment of nurses and consultants and facilitate closing working and information sharing with a local hospice.
Meeting people’s individual needs

The service mostly took account of patients’ individual needs.

End of life patients mostly received care in a side room. Relatives were supported with refreshments and special parking permits which allowed them to use car park facilities at minimum cost. These permits were available for all members of the family. Relatives told us they were able to visit the ward at any time when their relatives were approaching the end of life.

There were various printed information leaflets available to patients and their relatives. The chaplaincy provided leaflets on how to support people from different faiths. We did not see information available in languages other than English or in an easy-to-read format. The trust had a translation service for patients and relatives who did not speak English.

Staff told us they had received training in meeting people’s individual needs, for example dementia training. There was a virtual tour module which enabled staff to experience life for a patient living with dementia. One patient we visited was living with a learning disability and there was clear evidence in the patient’s notes that they had been supported regularly by a learning disability link nurse.

The trust told us they had experts by experience from the visually impaired, hearing impaired, physically disabled and learning disabled communities who acted as advisors in the practice of providing accessible information to patients, families and carers and effective communication for people with communication difficulties. Some staff had been on introduction to Makaton training. Following feedback, the trust had started working with Open Sight to develop a programme of work to improve signposting for people with a visual impairment.

Ward staff told us that when a patient died, families were able to spend time with their relative. Staff would complete last offices and then the patient would be transferred to the mortuary as soon as possible. Leaflets were given to families and they had an opportunity to visit the bereavement centre, often personal belongings were collected from the bereavement centre.

Mortuary viewing facilities were appropriate and allowed relatives privacy. It was accessible from the outside, meaning family members could avoid passing through the mortuary. The room was appropriately furnished and staff were available to answer questions.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patients were referred to the hospital palliative care team by ward staff, either by fax or telephone. Not all patients at the end of life were referred to the team. Referrals usually were placed when additional end of life support was required. The team told us they were available to anyone who asked and had never refused a referral. Staff told us they would refer to the palliative care team for support with symptom control, psychological distress or support for relatives. Staff in ED told us they found the palliative care team accessible and felt extremely well supported by them. The palliative care team carried out an audit in September and October 2016 which demonstrated that 81% of patients referred were seen and assessed on the day of referral and 16% were seen the day after referral. This showed patients were able to access the service when they needed it.

The trust had an Integrated Discharge Service (IDS) housed in the same room combining Hants in-reach service, Portsmouth in-reach service, Hants social services, Portsmouth social services and Portsmouth hospital discharge planning team. This new approach meant there was effective
and joint working between teams ensuring the best outcome for the patient. The rapid discharge service had worked hard to shorten the time from decision to discharge for patients by innovative working with Clinical Commissioning Groups (CCGs). During the period November 2017 to January 2018 96 patients required fast track discharge. The trust were able to discharge 69 of these patients within the two week time frame. There was a marked difference between the two local authorities the trust worked with. An average number of days waited for discharge for one trust being 2.7 days and 8.5 days for the other. The Portsmouth IDS had clearly identified: what the Fast Track (FT) pathway should look like; what should happen each day; the paperwork to be filled in and owned by the wards and the patient’s preferred place of care. Effective monitoring meant they could clearly identify the source of any delay. The Portsmouth IDS team then quality checked the referrals before they were sent to the FT team.

A patient feedback survey identified that approximately 20% of relatives fed back that the hospital was not their preferred place of death and as a result work had been developed to improve fast track discharge for patients very near to the end of their life. During the inspection we observed that significant progress had been made in this area.

The Trust had invested in the ‘QA@Home’ service to support the discharge of appropriate patients who were fast-track patients and wanted their care to be delivered at home. This would bridge the start date of care agencies and helped to bring forward discharge dates for a small group of patients.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust told us there had been some difficulty in identifying end of life complaints from general complaints, as often a complaint covered multiple areas and was not purely about end of life care. However the trust reported through the provider information request that from January 2017 to December 2017 there were 14 complaints about end of life care. The trust took an average of 48 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 30 working days. The main themes of complaints related to delays and communication issues. We reviewed a complaint from a relative who had been unhappy with end of life care at a weekend when the palliative care team were not available. The correct procedure had been followed and the complainant had been invited to a meeting to discuss their concern with ward staff and the complaints team. Actions were taken as a result of the meeting.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The hospital palliative care team were managed by the medical and older people rehabilitation services.

There was a strategic end of life lead for the trust and a clinical palliative care lead for the trust. The strategic lead for the trust chaired the end of life steering group, supported by the Chief Nurse. The Clinical Palliative Care Lead also provided medical leadership to the end of life team. Doctors and nurses on wards told us the consultant was visible and knowledgeable regarding palliative care in the organisation. Staff were engaged and motivated to provide a high quality service. Since the new executive team had come into post, the end of life lead reported a definite
shift in board priority towards end of life care.

Clear approachable leadership was demonstrated in mortuary services. The staff expressed dedication and pride at working in the department and were complimentary about their leader. A ‘huddle’ was used at the end of each shift to check in with each other and ensure everyone went off shift at the same time.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Evidence from inspection demonstrated the values throughout the trust regarding end of life care. There were clear values of wanting all end of life care patients to achieve a good death. All staff saw it as their responsibility and inherent within their role.

Priorities for improvement in the last financial year were promoting priorities of care, promoting the amber care bundle, improving discharges, improving use of the APOC planning documentation and improved bereaved relatives feedback. We saw clear evidence during our inspection that all areas had been targeted and improvement reported. Priorities for the next financial year were to improve the trust-wide use of the butterfly symbol, support early recognition of end of life to prevent bed moves, improve communication and improve confidence in caring for patients at the end of their life.

The palliative care team told us they had been involved in discussions regarding the end of life strategy for the trust.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We found staff to be open and transparent. Staff in the mortuary and bereavement centre told us they were extremely proud to be working there and both departments had consistently won hospital awards demonstrating how much they valued their staff. Staff demonstrated a ‘can do’ approach and went out of their way to ensure patients and their relatives felt they were an important part of the care delivery. The trust had a system in place for rewarding excellence, which made staff feel valued.

The trust carried out regular ‘Schwartz’ rounds. This is a system of staff meetings and discussion, which provides opportunity for staff from all disciplines to reflect on emotional aspects of their work.

**Governance**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust end of life steering group co-ordinated the service across the trust. The steering group was chaired by the end of life trust lead and attended by the palliative care consultant, the Director of Nursing, a non-executive director and two lay members. The steering group reported to the Medical Director who was the clinical effectiveness lead. The purpose of the group was to look at best and worst practice and to use the incident reporting system (DATIX) to identify issues for learning at ward level and areas to target education. CSC leads took learning back to share across their clinical service centre.

There was a standard operating procedure for the function of the hospital palliative care team which described purpose, scope, duties and responsibilities and process. It also included training requirements and a quality impact statement. We observed that staff worked within the scope, irrespective of diagnosis and ward staff followed the process.
Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The palliative care team had identified staffing as a key risk for the risk register, as due to staff shortages they had only been able to be reactive rather than proactive in their approach. Referrals had increased over the last year and actions had been taken to mitigate the risks identified. There was active recruitment of palliative care nurses and consultants and plans to work with specialists from a local hospice. Other mitigation including delegating educational work and an escalation plan for out of hours and at the weekend. This meant there was no impact on the effectiveness of the team.

The trust had identified metrics to monitor the performance of end of life care and were working with information technology (IT) to develop a dashboard. Fast track discharges were regularly monitored and the trust had been working hard with local authorities to reduce the length of time it took to discharge a fast track patient.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The end of life team collected data, such as through care for the dying audit. This was used to compare to other trusts and develop and the service.

We saw that staff were signposted to use confidential waste bins to ensure that paperwork which included person information was safely and appropriately disposed of.

Data was protected using the trust’s information management system. Staff had individual passwords and logins. Staff were encouraged to regularly change their password.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The end of life lead had worked with council sustainability and transformation partnership (STP) leads and Clinical Commissioning Group (CCG) leads regarding joint working around improving advanced care planning and possible admission avoidance with the aim of achieving a seamless integrated pathway across the health economy. They were looking as a network to adopt the Recommended Summary Plan for Emergency Care and Treatment (ResPECT) tool. There were plans, in collaboration with community partners, to access an electronic palliative care co-ordination system to use The Future planning template for palliative care and end of life patients, via the summary care record.

The mortuary had established links with the local ambulance service and with Portsmouth University for paramedic placements. There were also links with the coroner, various funeral directors, police and other departments within the hospital and local hospice. This shared responsibility and mutual understanding ensured bereaved relatives were not subjected to additional stress.

The bereavement lead had been recruited to a cremation national working party.

The trust offered bereaved relatives the opportunity to participate in a survey related to the last days and hours of the person who died. 90% of people felt they were adequately supported through the last two days of their loved ones death. The survey was amended in July 2017 following feedback that some of the questions were ambiguous. Since the amendment in July 2017, 223 people had provided feedback to the trust. As a result the trust had commissioned specialist training (Sage and Thyme) for all staff. We saw this had been implemented across the
trust, staff told us about the opportunity to complete the training and the palliative care team told us they had been involved in delivering the training.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The palliative care consultant told us he had spent a week working with end of life patients in ED. This enabled him to build relationships with the wider team and teach end of life in practice for example helping to identify patients where further investigations would not be in the patients’ best interest.

The trust has an established mortality review panel (MRP), which is held every weekday to review all adult (non-maternity) in-patient deaths within the past 48 hours. A Mortality Review Tool is used to create an electronic record of the conclusions of the panel, and learning points are summarised. In the MRP, each case is discussed using a structured tool, by clinicians independent of the specialty. The case review includes an initial assessment of potential avoidability, and identification of areas of concern or opportunities for learning that may require further investigation. The electronic record is shared for discussion in local mortality and morbidity meetings and at the monthly mortality review group. We found the mortality review panel to be an open, transparent, collaborative and blame-free environment. It was led by consultants trained in the process.

Junior doctors reported that they found it to be a useful opportunity to reflect on aspects of good care delivered, potential opportunities for improving care, and personal and team learning. We observed plaudits shared for an individualised care plan using the Achieving Priorities of Care (APOC) tool, discussion around earlier opportunities for advanced care planning, appropriateness of hospital admission and discussion around the appropriateness of planned investigations in the palliative setting. This included use and documentation of the Mental Capacity Act 2005.

We also interviewed doctors in the emergency department (ED) about how learning from deaths has been implemented for deaths occurring in the emergency department. Following a death in ED relatives were offered a follow up meeting either by telephone or face to face. Incidents and complaints were investigated by a consultant and learning points shared with the team.

ED, all deaths within the previous 24 hours are reviewed by the duty doctor (education registrar) and consultant each weekday morning. The cases are reviewed and if there are any concerns, they are reported to the coroner. If there are any serious incidents (SIRIs), near misses or suggestion of an avoidable death (using the Hogan scoring system), the cases are presented at the ED M+M meeting, and learning shared via email.
Portsmouth Hospital NHS Trust outpatient services for adults are mainly provided at Queen Alexandra Hospital. Outpatient clinics are also held at satellite sites including at St Mary’s Hospital in Portsmouth, St Richard’s Hospital in Chichester, Gosport War Memorial Hospital, Fareham Community hospital, Oak Park Havant and Petersfield Hospital. Each year this trust facilitates over 870,000 outpatient appointments.

There was a separate children’s main outpatient department, which is reported under the children and young people core service. Some children were seen in regular outpatient clinics for ear nose and throat (ENT) at Queen Alexandra Hospital.

The trust provides consultant and nurse-led outpatient clinics across a range of specialities. Outpatient clinics are held from Monday to Friday 08:30am to 5pm. Some ad-hoc Saturday appointments were available dependant on speciality. Patients can make appointments through the centralised outpatient booking centre between 8.30am and 5pm Monday to Friday or directly with the department for some specialities.

During this inspection we spoke with 65 staff, including managers, doctors, therapists, nurses, healthcare assistants, cleaners and volunteers. We spoke with 26 patients and relatives. We looked at patient waiting areas, clinic environments and reviewed policies and procedures.

**Total number of appointments compared to England**

The trust had 818,065 first and follow-up outpatient appointments from December 2016 to November 2017. The graph below represents how this compared to other trusts. The graph shows that the trust was in the upper quartile for number of appointments provided.
Number of appointments by site

The following table shows the number of outpatient appointments for the three main sites delivering outpatient services, a total for the trust and the total for England, from December 2016 to November 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Alexandra Hospital</td>
<td>859,154</td>
</tr>
<tr>
<td>St Richard's Hospital</td>
<td>13,887</td>
</tr>
<tr>
<td>St Mary's Hospital</td>
<td>249</td>
</tr>
<tr>
<td>This Trust</td>
<td>873,809</td>
</tr>
<tr>
<td>England</td>
<td>103,863,724</td>
</tr>
</tbody>
</table>

Number of appointments by specialty

Portsmouth Hospital NHS Trust delivered 873,809 appointments from the following locations:
- Queen Alexandra Hospital
- St Richard's Hospital
- St Mary's Community Health Campus
- Fareham Community Hospital
- Gosport War Memorial Hospital
- Oak Park Community Clinic
- Petersfield Community Hospital
  The trust reports that it delivers 1,515 outpatients clinics each week, providing care in the following areas:
  - Audiology
  - Bariatrics
  - Breast Outpatients Department
  - Colorectal
  - Dermatology
  - Diabetes and Endocrine Department
  - ENT
  - Endoscopy Suite
  - Gastroenterology
  - Gynaecology
  - Hepatology
  - Maxillo-facial
  - Neurology
  - Oncology Service
  - Ophthalmology
  - Oral surgery
  - Orthopaedic and fracture clinics
  - Outpatients.
  - Paediatric Outpatient Department
  - Plastics Outpatients Department
  - Renal Outpatients
  - Respiratory Outpatients
  - Rheumatology
  - Surgical Outpatients Department
  - Urology Outpatients Department
  - Vascular

(Source: Routine Provider Information return)

**Type of appointments**
The chart below shows the percentage breakdown of the type of outpatient appointments from December 2016 to November 2017. The percentage of these appointments by type can be found in the chart below:

**Number of appointments at Portsmouth Hospitals NHS Trust from December 2016 to November 2017 by site and type of appointment.**

The number of appointments cancelled by the hospital at St Richard’s Hospital is higher than the
Is the service safe?
By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training
The service provided mandatory training in key skills to all staff. However, Nursing staff compliance with some mandatory training courses was low.

Staff received effective mandatory training in safety systems, processes and practices. Staff completed mandatory training in a range of subjects including health and safety, infection prevention, dementia awareness and basic life support.

Staff we spoke with reported they had time to complete mandatory training during working hours

Senior staff regularly monitored compliance with mandatory training using an electronic system. We saw that compliance with mandatory training was included in clinical service centre governance meetings.

Mandatory training completion rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 85% for completion of mandatory training, with the exception of information governance which has a target of 95% completion rate.

A breakdown of compliance for mandatory courses from April 2017 to January 2018 for nursing/midwifery staff in outpatients is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>10</td>
<td>13</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>6</td>
<td>13</td>
<td>46%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>6</td>
<td>13</td>
<td>46%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 88%. The trust met the completion target for 10 of the 15 courses made available to nursing staff with seven of these having 100% completion rate. The trust failed to meet the target for five modules including adult basic life support which had a completion rate of 46%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise abuse and they knew how to apply it.

Clinical staff understood how to recognise and report a safeguarding concern. Staff we spoke with told us they would talk their concern through with another colleague then escalate their concern to the safeguarding lead, matron or nurse in charge. However, some clerical staff in ophthalmology were not aware of how to report a safeguarding concern.

We saw that information on safeguarding from abuse was displayed in waiting areas.

The service displayed information in outpatient reception areas on how to request a chaperone. This informed patients that a chaperone of their own gender was available to accompany them during their appointment on request.

Staff we spoke with confirmed female genital mutilation (FGM) and child sexual exploitation (CSE) training was included in safeguarding training. We saw that in the January 2018 muscular skeletal (MSK) governance meeting minutes staff were reminded that new guidelines on preventing CSE were on the trust intranet.
Clinical leads were aware of the guidance for safeguarding level three training for children. We requested evidence of safeguarding training and competency for adult nurses that treat children in outpatient areas. The trust responded that children were seen by adult nurses in ENT outpatients, hand clinic and eye casualty treated children. The trust did not provide evidence of safeguarding children level 3 and told us they were working on rolling out this training to adult nurse staff who treated children. We saw that when children were being seen in ENT clinics staff had access to a children’s nurse who was trained to safeguarding children level 3 and was the safeguarding lead for the outpatient area. Staff had access to advice from the paediatric unit at all times. This mitigated the risk of adult nurses treating children however, the trust must ensure that all staff that treat children in outpatient areas must have specific competencies to treat children and be trained to safeguarding children level 3.

**Safeguarding training completion rates**
The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to January 2018 for nursing/midwifery staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Portsmouth Hospitals Trust met the target for all three safeguarding courses made available to nursing staff, all modules had 100% completion rate. Medical staff training data is not available for outpatients as medical staff are managed by their specialities.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**
The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

All outpatient areas we visited were visibly clean. The service had reliable systems in place to prevent healthcare associated infections.

Staff received training in infection, prevention and control during their induction as part of mandatory training. Trust data showed that 100% of nursing staff had completed this training.

Staff could describe how they would manage a patient with an infectious condition, for example by ensuring the patient was seen in an isolated clinic room that was deep cleaned after the appointment. Staff we spoke with in rheumatology and fracture clinic knew how to contact the infection control link nurse for advice.

The service monitored compliance with hand hygiene well. We reviewed the monthly hand hygiene audit results for outpatient areas and found compliance was consistently 100% for the phlebotomy service, fracture clinic and renal outpatients at Queen Alexandra hospital for January to May 2018. Most outpatient areas scored above 95% in the hand hygiene audits for January
During the inspection we saw staff washing their hands before and after patient contact. Staff wore uniforms and were bare below the elbow in line with trust policy.

Hand sanitiser gel was available in all outpatient areas. Patients were encouraged to use hand sanitiser gel before entering clinic areas.

Across all outpatient areas we visited we saw clean equipment was labelled with 'I am clean' stickers so staff knew the items were clean and ready for use. We saw cleaning schedules were signed and completed for clinic rooms at Gosport War Memorial Hospital outpatients.

Staff in the respiratory and ear, nose and throat (ENT) departments had a good understanding of the cleaning process for scopes. We observed good infection control procedures for managing scopes. For example, in the ENT department dirty scopes were covered with red plastic and clean scopes were covered with green plastic. We saw that there was a good audit trail of the cleaning of scopes with the serial numbers of the scopes recorded.

Staff we spoke with at Fareham community hospital confirmed that only single-use equipment was used for minor procedures.

In renal outpatients there were fabric covered chairs in waiting area and clinics and carpet in the education room. The matron was aware of these infection control risks but they were not recorded on the risk register for the renal service.

At the time of the inspection cleaning staff were employed by a private contractor. We requested the cleaning schedules for all ophthalmology areas at Queen Alexandra hospital and found that there was a detailed schedule for daily, weekly and thorough cleaning including daily tap flushing.

We reviewed the National Patient Safety Agency (NSPA) audit for ophthalmology theatres and found the service carried out the audit once or twice a month. Data the trust provided showed the trust scored consistently above 90% October 2017 to March 2018. We saw evidence that where issues were identified the relevant staff were informed to improve the cleaning of these areas.

The sluice in ophthalmology theatres was located across a corridor used by patients. We requested the infection control risk assessment and found that this had been added to the risk register following the inspection with actions to mitigate the risk in place.

The trust had a water safety committee that met every other month to ensure that water facilities were safe across all sites. We reviewed the minutes of the water safety committee minutes for March 2018 and found peripheral sites were included on the set agenda.

**Environment and equipment**

The service did not always have suitable premises. Some outpatient waiting areas in the eye department and renal outpatients were not suitable for the volume of patients attending clinics.

Most waiting areas in outpatient areas we visited at Queen Alexandra hospital had enough seating for patients. However, some outpatient waiting areas were not suitable for the volume of patients attending. The waiting area for phlebotomy was small and patient sometimes had to wait in the corridor where there was also seating available. The waiting area in ophthalmology was cramped for the volume of patients attending clinics. Staff we spoke with told us this had been risk assessed. We requested the fire risk assessment for the ophthalmology department and the trust responded that there was no environment specific risk assessment.

At Fareham Community Hospital and Gosport War Memorial hospital the outpatient areas had enough seating for patients.
All outpatient areas had emergency medicines and resuscitation equipment that was readily available and in date. Daily checks were recorded and emergency medicines were stored in tamper evident boxes. We saw that all daily checks for resuscitation equipment were completed in past month, March 2018, in cardiology, rheumatology and oncology outpatient areas.

The service looked after equipment well. Staff could describe the trusts’ maintenance system and how to report problems with equipment. The trust maintained an asset register for all equipment. We checked 10 items of equipment for electrical safety testing and found they were in date for testing. We saw that the scales in ophthalmology and surgical outpatients were calibrated within the past year.

However, in ophthalmology, staff told us not all servicing contracts were in date. We requested the servicing contracts for ophthalmology but the trust submitted details of the contracts without renewal dates.

**Assessing and responding to patient risk**

Systems and procedures were in place to assess, monitor and manage risks to patients.

The service monitored referral to treatment (RTT) data weekly for all medical specialities.

Waiting lists for outpatient appointments were reviewed at a weekly patient list meeting for cancer patients. Risk assessments and treatment plans for patients who breached internal targets for weeks waited for treatment were reviewed at this meeting.

Staff checked the patient’s date of birth and first line of their address to check their identity when they booked in for an appointment.

If a patient became critically unwell in an outpatient area, staff would monitor them and check their vital signs then call the hospital internal telephone number for emergency assistance if needed. Staff also sent patients for assessment, where appropriate.

The service had a clear process for outpatients to be admitted to the hospital if they became clinically unwell. Staff we spoke with were aware of the process for escalation of unwell patients and would monitor the patients vital signs and request emergency assistance from on call medical staff by calling the hospital switchboard. The sister in the fracture clinic at Queen Alexandra Hospital had arranged sepsis awareness training for staff.

Specialist nurses provided a fracture liaison service was based in the fracture clinic to carry out a fracture risk assessment and treatment for osteoporosis with the aim of preventing further fractures.

National Safety Standards for Invasive Procedures (NatSSIPs) were embedded in the organisation. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs) and dedicated LocSSIP checklists were used for invasive procedures such as taking biopsies, removing lesions and injections into eyes. We saw evidence of this in the nurse-led dermatology clinics, respiratory and ophthalmology theatres. We reviewed four LocSSIP checklists for cataract surgery and found them to be completed appropriately.
**Nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There are no agreed national guidelines as to what ‘safe’ nurse staffing levels are in outpatient areas. Staffing levels and skill mix were planned based on the number of clinics and patients attending. Nurses were flexed to provide cover within other outpatient clinics across surgical, rheumatology and fracture clinic outpatient areas at Queen Alexandra hospital.

The service had enough staff. The senior sister told us surgical outpatients was currently fully staffed. Surgical outpatients nursing staff worked across some of the satellite sites. However, in renal outpatients staff told us clinic numbers were increasing but staff numbers reducing.

In ophthalmology senior staff told us they were staffed for the resources available to them in the department but not to meet the level of demand for clinics. Senior staff reported eye casualty was short of three full time staff nurses across the department.

In ophthalmology staff told us clinics were not cancelled even when there was only one photographer. We reviewed incidents relating to staffing reported in ophthalmology and found this incident had not been reported. The two staffing incidents reported related to short notice sickness.

At the time of our inspection, nurse staffing met the needs of patients. We found across outpatient departments bank and agency staff were rarely used.

Specialist nurses were widely employed across the trust providing specialist care to patients and training staff.

Nursing staff were shared across fracture clinic, pain clinic and rheumatology. Fracture clinic nurses also sometimes supported on orthopaedic wards and in the emergency department.

The trust has not provided any planned versus actual staffing information for outpatients. This was requested during the inspection but not provided as staff were managed by their individual specialities.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017, Portsmouth Hospitals NHS Trust reported an annual over-establishment of 13.2% for nursing staff in outpatients.

The trust did not provide a target for vacancy but the trust total for all staff groups was 7.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017, Portsmouth Hospitals Trust reported a turnover rate of 10.7% in outpatients, compared to a target of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017, the trust reported a sickness rate of 5.2% for nursing staff in outpatients which was worse than the trust target of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
All medical staff worked and were managed by speciality specific clinical service centres. Staffing levels and skill mix were planned based on the number of clinics run within the service. Medical staffing was provided by the specific specialties that were holding the clinics such as ophthalmology, cardiology and rheumatology.

Consultants arranged outpatient clinics directly with the outpatient nursing staff to meet the needs of their patients.

The trust has not provided any planned versus actual staffing information for outpatients. This was requested during the inspection but not provided as staff are managed by their individual specialities

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017, Portsmouth Hospitals NHS Trust reported an annual over-establishment of 2.6% for medical staff in outpatients.

The trust did not provide a target for vacancy but the trust total for all staff groups was 7.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported a rolling turnover rate of 0% for medical staff in December 2017 which was better than the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
From December 2016 to November 2017, Portsmouth Hospitals Trust reported a sickness rate of 0.1% in outpatients which was better than the trust target of 3.0%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records
Staff kept appropriate records of patient’s care and treatment. Records were, clear, up-to-date and available to all staff providing care. However, records were not always stored securely in all outpatient areas.

Paper medical records were not always stored securely in lockable trolleys to maintain patient confidentiality at Queen Alexandra hospital. For example, we saw that patient letters were left on top of the reception desk visible to patients in ophthalmology outpatients. Records were stored in unsecured boxes in areas that were accessible to patients in the fracture clinic.

We observed that computer screens locked when not in use and cabinets containing health records were locked. We saw at Fareham community hospital outpatients patient notes were stored securely in the nurses offices which was locked when not in use.

Records were stored at an off-site building three miles from the main hospital site. Portering staff transported records between the off-site facility and the main site five times a day. Records were paper-based and required a large volume of administrative staff to maintain them and ensure their availability. We saw that clerical staff tracked all notes using a tracker form.

The trust audited the availability of patient notes for outpatient clinics. The target of 98% of notes available for clinics was met June 2017 to December 2017.

Clerical staff we spoke with told us they prepared a temporary file with the patient referral letter if the full clinical notes were not available. If this was not appropriate for the clinician the appointment would be rescheduled.

There was no overarching strategy for moving towards paper-light records. The records manager told us the urology department had piloted use of paper-light records.

People with a learning disability or a mental health condition were not always flagged on notes. Staff used information in the referral letter to check if a patient had additional needs.

We saw that confidential waste was stored securely and disposed of appropriately.

Medicines
Medicines were stored securely and suitable emergency medicines were regularly checked, appropriately stored and available. However, daily fridge temperature checks were not always recorded and prescription stationery was not always tracked and audited to reduce the likelihood of misuse.

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. All outpatient areas managed medicines in a suitable way to ensure patients were kept safe from avoidable harm.
Medicines could be supplied to patients from a stock of TTO packs if needed. These were checked by the doctor and recorded in the patient notes. FP10 prescriptions were available to be supplied if needed (for example when the pharmacy was closed).

Prescription stationery was stored securely but the use of prescription forms was not always tracked and audited to reduce the likelihood of misuse. We found four FP10 prescriptions in dermatology outpatients at St Mary’s Hospital that had not been logged by staff. The department had a log book to track the use of FP10s but whilst the matron was on holiday staff had not filled in the log. At Queen Alexandra hospital oncology outpatients and oncology day ward FP10s were stored securely but there was no log book to track use. During the inspection we raised this risk and the trust took action to remind staff about the policy for FP10 prescription security. Following the inspection, the trust audited the FP10 logbook and found no FP10s were missing but the logbook had been completed in the wrong order. We saw that the safety reminder regarding FP10s was displayed on the medicines cupboard at Gosport War Memorial hospital outpatients.

We found staff recorded fridge temperatures daily and checked they were in range in all areas we inspected except for one. At satellite clinics fridges were only checked when clinics were running. In ophthalmology theatres 13 dates in March 2018 had not had fridge temperature checks completed. Fridge one in ophthalmology theatres was recorded as consistently out of range. Staff told us this fridge had been risk assessed by pharmacy. We requested the risk assessment of fridge and found the fridge had been risk assessed by pharmacy following an incident where it had been accidentally unplugged.

We saw that most medication fridges were locked when not in use but we found the medication fridges were not locked in rheumatology day patient unit. In the oncology day unit at Queen Alexandra hospital controlled drugs were stored securely and the controlled drugs register was completed fully.

We saw that the departments kept a low stock of drugs and all drugs we checked were in date. Staff we spoke with in rheumatology outpatients told us they had good links with the pharmacist.

Chemotherapy drugs were managed safely. Some chemotherapy was made up in Urology outpatients. We saw that this was done in a safe way following a clear procedure. We observed nurses double-checking the identity and reason for treatment before administering chemotherapy on the oncology day unit at Queen Alexandra Hospital.

Patient group directives (PGDs) were used in the ophthalmology service to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. We saw that these had been authorised and signed appropriately. A record was kept of all instances where a medicine was administered under a PGD within the department.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff understood what to report as an incident and how to report through the trust electronic
reporting system. Staff could give examples of incidents they had reported. For example, a patient lost to follow up in urology outpatients, medicine errors, a needle stick injury and a pregnant woman fainting in phlebotomy. Most staff could describe learning from incidents. For example the phlebotomists try to meet women in maternity outpatients to take blood so they are seen in a less busy environment.

Staff we spoke with did not always receive feedback from incidents they reported. This could mean opportunities for learning were lost.

Staff told us incidents discussed at monthly ward meetings. We saw that incidents, including serious incidents and never events were discussed at CSC level clinical governance meetings.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported one incident classified as a never event taking place in outpatients. This took place in December 2017 at ophthalmology outpatients at Queen Alexandra Hospital where an intravitreal injection was given to the wrong eye.

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with in the eye department were aware of learning from a recent never event. We reviewed the root cause analysis investigation for the never event and found that it was investigated in line with the trust policy.

We saw that learning from the December 2017 never event in the eye department had been implemented to address to human factors that had led to the event. For example we saw that “do not disturb” posters were on doors to ensure staff were not interrupted whilst carrying out procedures. The manager distributed a ‘watch out poster’ with safety learning following event circulated to staff. Eye department staff we spoke with were aware of the learning from the recent never event.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in outpatients all at Queen Alexandra Hospital which met the reporting criteria set by NHS England from February 2017 to January 2018.

Four of these were relating to ophthalmology outpatients with three diagnostic incidents including delay meeting SI criteria (including failure to act on test results) and one treatment delay meeting SI criteria. Audiology outpatients reported a diagnostic incident including delay meeting SI criteria (including failure to act on test results).

(Source: Strategic Executive Information System (STEIS))

We reviewed the root cause analysis investigations for the serious incidents reported relating to outpatient areas and found that serious incidents were fully investigated in line with trust policy.

The investigation reports included evidence of Duty of Candour conversations and letters sent to patients involved. Staff we spoke with were aware of Duty of Candour and the principles of being open and honest with patients when things went wrong.

Staff were aware of learning from incidents. For example, following a serious incident a standard operating procedure for cancelled appointments had been developed. There was a clear escalation process if capacity prevented booking an appointment in the required time frame and
administrative staff we spoke with were aware of this process.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were available on the hospital’s intranet. Staff we spoke with referenced policies and protocols relevant to the speciality in which they worked. Senior staff reviewed clinical policies at clinical service centre governance meetings.

Medical specialities conducted audits of compliance with NICE guidance. We requested evidence of audits for compliance with NICE guideline in outpatient areas and found, for example, a NICE quality standard gap analysis tools had been completed for antimicrobial prescribing guideline NG84 and the trust was 100% complaint with the recommendations.

The heart failure service one-stop clinic was achieving 99% rate of seeing patients within the two week standard as recommended in the NICE guideline pathway for diagnosing and assessing chronic heart failure.

The nurse-led rapid access chest pain clinic was designed to meet the requirements of NICE guideline CG95 ‘Chest pain of recent onset: assessment and diagnosis’ last updated November 2016 and the national service framework for coronary heart disease (2000). Patients could be referred to the service from a GP and be seen within two weeks. Patients were seen by an advanced clinical practitioner who devised management plans and offered health promotion advice.

**Nutrition and hydration**

Staff ensured patients had enough food and drink during their visit to outpatients.

Water was available in all outpatient waiting areas we visited. The hospital had a selection of places to eat in or purchase food and drink.

Staff were able to provide hot meals to patients whose transport had been delayed over a mealtime. Patients in renal outpatients and the dialysis unit had access to snacks. Dietitians were available to support transplant patients.

**Pain relief**

Patients were not routinely assessed for pain in outpatients, as this was not generally a clinical risk. However, staff discussed simple oral analgesia and its use for patients at home and gave advice when to seek guidance.

The service provided a dedicated pain clinic at Queen Alexandra hospital.

The rheumatology outpatient service ran a back pain information session on a Friday.

**Patient outcomes**

Clinical audits were not routinely carried out within outpatient services. Some specialities had their own audit programmes. For example respiratory outpatients had an audit programme.
The results of the first national benchmarking audit for outpatient services the trust had participated in were not due until September 2018.

Consultants were in the process of evaluating and auditing patient outcomes from virtual fracture clinic. In the year 6th June 2016 to 6th June 2017 there were 9985 attendances and the virtual fracture clinic was able to discharge on average 33.67% of patients.

The renal service was in the process of auditing patient outcomes for the REACT clinic at the time of the inspection.

**Follow-up to new rate**

From December 2016 to November 2017, the follow-up to new rate for Queen Alexandra Hospital and St Richard’s Hospital was worse than the England average. The follow-up to new rate for St Mary's Hospital was generally worse than the England average throughout the reporting period, with the exception of March 2017 which saw a peak exceeding the England average.

**Follow-up to new rate, Portsmouth Hospitals NHS Trust.**

![Graph showing follow-up to new rate](image)

(Source: Hospital Episode Statistics)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff we spoke with had yearly appraisals with their manager. The trust performance appraisal form included space for discussion of success and challenges and was aligned to the trust values.

There was a clear structure for setting objectives with managers.

Most staff we spoke with were positive about opportunities for further training. However, nursing staff did not have protected time for learning in ophthalmology due to demand on service. Staff we spoke with told us they did not have access to further training due to lack of time and funding.

Staff we spoke with in ophthalmology had completed trust induction and a local clinic specific induction. Staff were allocated a ‘buddy’ to mentor them.

Practice educators and clinical nurse specialists worked across outpatients areas.
Specialist nurses worked across outpatient areas. For example, in respiratory outpatients there was a specialist mesothelioma nurse funded by a national charity to support patients with asbestos related cancer.

We saw that nurses completed competency frameworks to ensure they were competent to carry out their role. Outpatient nurses used the general trust nursing competency framework and completed additional competencies specific to the medical speciality they were working in. We reviewed a sample of staff competency frameworks for nurses in urology, respiratory and dermatology outpatients and found them to be detailed and fully completed.

In ophthalmology theatres staff were in the process of developing a surgery training manual for staff. Three nurses had been developed into nurse injectors.

The service provided nurse led clinics across outpatient areas. For example in cardiology there was a nurse-led clinic for review of insertable cardiac monitoring systems and a nurse-led clinic provided a ‘see and treat’ service in dermatology.

Nursing staff we spoke with told us they had access to Schwartz rounds and study days.

Staff were positive about support for training and development. For example staff were positive about support from the trust to complete nursing associate training and support with maths and English.

In cardiology outpatients the lead clinician held a training session that all staff could attend.

**Appraisal rates**

From April 2017 to March 2018, 86% of staff within outpatients at the trust had received an appraisal which was better than the trust target of 85%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>67</td>
<td>67</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>35</td>
<td>28</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>37</td>
<td>24</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>147</td>
<td>127</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing midwifery was the staff group with the lowest appraisal completion rates of 65%, failing to meet the 85% target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff of different grades and skills worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Outpatient teams worked together to plan and deliver care and treatment. Nursing staff we spoke with reported they had good working relationships with consultants. Clinical nurse specialists worked in clinics including rheumatology and respiratory departments. These staff worked closely with consultants to improve patient care.
Some specialities had multidisciplinary team meetings. For example, fracture clinic staff had a monthly multidisciplinary meeting attended by any consultants, nurses, clerical staff and secretaries.

The bariatric clinic was a one stop multidisciplinary clinic which included assessments by a psychologist, dietitian, surgeon and anaesthetist at the same clinic appointment.

Administration teams, reception staff, nurses and doctors worked well together to continuously manage outpatient waiting lists.

We saw that oncology staff and Macmillan nurses worked together to provide continuity of care for patients.

Discharge summaries were sent to patients’ GPs after their appointment or treatment. The trust audited the timeliness of letters sent to GPs from outpatient clinics. Data provided by the trust showed the majority of discharge letters were sent to GPs within five days of the appointment. And in the months January 2018 to March 2018 over 95% of letters were sent to GPs within ten days of the appointment.

**Seven-day services**

Outpatient services were provided across sites from 08:30am to 5pm Monday to Friday. Most clinics in the main outpatient department did not routinely provide a seven day a week service.

Some specialities ran ad-hoc clinics on Saturdays to reduce waiting lists. Cardiology clinics ran at weekend as required to meet demand.

There was no formal plan for seven day outpatient services. Out of hours and weekend clinics were organised on an ad hoc basis according to patient demand and consultant availability. Some clinics were available out of hours to meet demand. For example rheumatology day case clinic was open Saturday 8am – 2pm.

**Health promotion**

Staff were proactive in supporting people to live healthier lives.

Doctors and nurses promoted good health during consultations. Staff we spoke with told us that patients were made aware of health benefits from stopping smoking, reducing alcohol consumption, and maintaining a healthy diet. One patient we spoke with told us that he had been informed of healthy living during a consultation.

Staff in dermatology were aware that the local community had higher numbers of ex-military personnel, and would guide them to Veteran associations for further support after treatment. Dermatology staff carried out outreach visits and visited the local university on several occasions a year to do mole checks for staff and students and promote sun safety.

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Clinical staff we spoke with had a good understanding of informed consent.

Patient records we reviewed contained evidence of appropriate consent, where required. We reviewed four consent forms in patient records in ophthalmology and found they were completed and signed appropriately.
Patients we spoke with told us their care and treatment had been fully explained.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2017 to January 2018, Mental Capacity Act (MCA) Level 1 training had been completed by 93% of nursing staff within outpatients, while level 2 had been completed by 92% of nursing staff. The trust did not provide information for medical staff in outpatients.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Deprivation of Liberty Safeguards (Introduction) training had been completed by 93.3% of nursing staff. The Deprivation of Liberty Safeguards (Enhanced) training attained a 100% completion rate, however this is based on one member of staff only. The trust did not provide training data for medical staff in outpatients.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty Safeguards (Enhanced)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (Introduction)</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion, kindness, dignity and respect. Feedback from patients was consistently positive and patients confirmed staff treated them with care and compassion. Patients we spoke with described staff as ‘highly professional’, ‘they always go that extra mile to help’ and told us they had received ‘excellent service.’

We saw many examples of positive feedback from patients across outpatient departments. We saw thank you cards from patients in respiratory and oncology outpatients thanking staff for their care.

Patients we spoke with were satisfied they were involved in their care decisions and told us they felt informed in every step of treatment given.

During our inspection we saw staff introduced themselves and took time to interact in a considerate manner. However, a staff member we spoke with in ophthalmology felt the demand on the service impacted on their ability to provide compassionate care as there was no time to chat with patients.
We saw reception staff were attentive to the needs of patients. For example we saw a receptionist come out of their desk to point a patient in the right direction for their appointment.

Staff understood the importance of chaperones. In dermatology posters (on treatment room doors) advertised chaperone services. We saw posters asking patients if they would like a chaperone were displayed clearly in surgical and dermatology outpatient areas. Senior staff carried out an audit of compliance against the trust chaperone policy in surgical outpatients. The November 2017 audit showed the service scored 100%.

Staff were committed to supporting their patients. For example, staff in the rheumatology department organised a ‘Funky Glove Day’ in February 2018 to raise awareness of Raynaud’s disease and raise funds for the department by selling hand-knitted gloves. The weekend after our inspection, staff from the fracture clinic went to London Marathon to support runners with injuries. We also saw that staff had arranged charity bags for men with prostate cancer in urology outpatients.

The privacy and dignity of patients could not always be protected due to the constraints of the environment in renal outpatients and ophthalmology.

The renal outpatient area was cramped for the volume of patients being seen. Due to limitations on space, patients were being weighed in an area visible to the waiting area. This did not respect patients’ privacy and dignity.

In ophthalmic department, vision tests were being conducted in areas not concealed from public view. This did not respect the patients’ privacy and dignity. During these examinations other patients were observed waiting close by. This location was in a corridor between two waiting rooms. Due to the lack of suitable clinic rooms staff told us two rooms in the imaging department in ophthalmology were used for clinics when these rooms had curtains rather than doors so conversations could be overheard by the patients waiting nearby.

The trust gathered feedback through the Friends and Family Test (FFT) survey, which allowed patients to state whether they would recommend the service. From 1 February 2018 to 28 February 2018 outpatient services had 100 responses to the FFT survey. Out of these responses 67 patients were extremely likely to recommend the service and 24 were likely to recommend the service. Overall for February 2018 91% of patients were likely to recommend the service. The response rate for the FFT survey was not recorded.

**Emotional support**

Staff understood the need for emotional support.

Staff had a good awareness of patients with complex needs and how to accommodate people by giving patients more time. In most outpatient areas staff had access to a quiet room where they could break bad news.

New patients in oncology would be guided around the department to ‘demystify’ cancer treatment. Staff showed patients treatment areas and introduced patients to staff. Staff would comfort patients and discuss any concerns in a quiet room.

Patients had access to a Macmillan support centre which was located next to oncology outpatients department. The centre was funded by Portsmouth Trust, and supported by volunteers. Macmillan support centre offers counselling services, support groups and therapeutic activities for patients. We saw a Macmillan support worker offering hand massages to patients. Staff and volunteers working at the Macmillan centre all had ‘sage and thyme’ training in breaking bad news.
Patients we spoke with knew how to contact the service if they had concerns about their treatment.

Patients were being observed treated on a personal level. For example, in oncology staff noticed a patient was distressed, so took the patient to a private room to comfort them and continue treatment.

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

Patients we spoke with told us their treatment had been explained clearly and they understood their care plan. Patients told us they had been given enough information to understand their condition. In rheumatology outpatients staff ran course to support patients to understand their condition and self-manage their condition better.

Across outpatients interpreters were available through a telephone service if requested.

In rheumatology outpatients nursing staff support patients to help them self-manage long term conditions. For example, the service ran a seven week fatigue management course ‘tired of being tired.’ Patients we spoke with confirmed they had been invited to courses.

Rheumatology also ran an advice line where patients can leave a message 24/7. Nurses would respond to patients in 24 hours. Nurses told us this was a well-used service as patients found it hard to get the right support from GPs.

**Is the service responsive?**

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

The trust planned and provided service in a way that met the needs of local people.

We saw services were planned to meet the needs of the local population. Clinics were provided at satellite units across Hampshire including at Gosport, Havant, Fareham, and Petersfield. Audiology, cancer and audiology, renal and oncology clinics were also provided in West Sussex at St Richard’s Hospital, Chichester.

Patients could select where they were seen through the NHS ‘choose and book; service, and could complete bookings online or via telephone. Patients were able to choose appointments at sites closest to their home. Patients were offered two appointment times as standard. Patients we spoke with told us the booking system was easy to use.

The service ran rapid access clinics. The service had a ‘Admission Avoidance Strategies’ document, dated January 2018, which included details of rapid access clinics that supported patients receive care in a timely manner without being admitted to the emergency department. Daily Monday to Friday rapid access clinics included: a cardiology admission avoidance clinic, a nurse-led fast access chest pain clinic and a nurse-led clinic for enteral tube-feeding problems.

Some specialities delivered walk-in clinics. For example, the respiratory department had a troubleshooting walk-in clinic for patients with sleeping problems. This walk-in clinic was available in the evening 17:30 to 19:00 and Friday afternoon.

In some departments the environment did not meet the needs of the volume of patients seen. The eye unit was too small to meet the needs of the numbers of patients and clinics running. We saw waiting areas were cramped. The renal outpatients waiting area was also very cramped due to demand on the service, the service was managing this by having a separate REACT clinic for more poorly renal patients and trying to get patients seen at satellite clinics.
We observed in the dermatology outpatient clinic at St Mary’s Health Campus the waiting areas outside the consultation rooms had no suitable space for wheelchair users. One wheelchair user was waiting in the corridor, due to limited space. It was also observed in the renal department during a busy period no comfortable space was allocated for a wheelchair user. In phlebotomy patients feedback told us the waiting area ‘lacked seats’ and was not disability friendly.

The main car parking for patients at Queen Alexandra hospital was a multi-storey car park with 880 spaces. The car park was managed by the hospital and patients and visitors could park for 15 minutes without a charge on arrival after which charges applied. At Fareham community hospital patients could park for three hours without a charge.

The main reception desk at the entrance to the hospital was staffed by volunteers to support patients to find departments. Staff we spoke with told us signposting of outpatients departments was sometimes a problem.

**Did not attend rate**

From December 2016 to November 2017:

- The ‘did not attend’ rates for Queen Alexandra Hospital and St Mary’s Hospital were lower than the England average. Queen Alexandra Hospital reported a 0% ‘did not attend’ rate from January to November 2017 which could indicate a problem with data submission.
- The ‘did not attend’ rate for St Richard's Hospital was similar to the England average.

The chart below shows the ‘did not attend’ rate over time.

![Proportion of patients who did not attend appointment, Portsmouth Hospitals NHS Trust.](image)

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service took account of patients’ individual needs, and the service planned and provided services in a way that met the needs of local people. Same day or next day appointments were available within many clinics, for example trauma and orthopaedics, for patients who required urgent treatment.

Patients with additional needs or requirements were not flagged on the appointment system but staff checked referral letters and encouraged patients and carers to inform the department if they needed extra support. Staff had access to a learning disability passport to support recording of patient’s communication needs. Managers of administration teams we spoke with told us they encouraged staff to spend extra time with patients with additional needs.
People with learning disabilities and mental health conditions were given the time they needed during consultations. They were provided with quiet areas in which to wait for their appointment, minimising distress often associated with coming to hospital. Clerical staff in ophthalmology were aware of how to contact the learning disability nurse if needed to support a patient. Staff in phlebotomy explained how they would arrange to see patients with a learning disability at the very beginning of the day when it was quietest.

The service had recently reviewed the patient information for surgical outpatients to support patients to come better prepared for their appointment.

The service had bariatric chairs available in outpatient waiting areas.

We saw there was clear signage in the ophthalmology unit for partially-sighted patients. A sight loss advisory service funded by the local authority was located in an office by the entrance to the ophthalmology department. An early intervention support worker was based in the office to offer patients advice on social care and charity services available to them.

Staff had access to a telephone translation service to support callers for whom English is not their first language. Staff could arrange telephone or face to face interpreters. We saw the automatic check in machine outside the fracture clinic could be operated in a range of languages including – French, Spanish, Polish and Nepalese.

We observed a range of relevant patient information leaflets were available in outpatient areas. Staff could access leaflets in large print and in different languages for patients if needed. For example in cardiology outpatients there was patient information on how to respond if someone collapses.

For patients with no fixed abode the referring clinician would be contacted with details of the patient appointment to pass on to the patient.

Access and flow

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, which then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient’s appointment is booked through the NHS e-Referral Service, or when the hospital or service receives the referral letter.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways
From December 2016 to February 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. From March to November 2017 the rate has been above the England average. The latest figures for November 2017 showed 90.2% of this group of patients were treated within 18 weeks compared to the England average of 88.8%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Portsmouth Hospitals NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

The 12 specialties in the following table were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100.0%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>99.7%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>97.7%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>97.4%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>97.3%</td>
<td>88.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>96.9%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>96.5%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.9%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94.1%</td>
<td>93.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>92.9%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Other</td>
<td>92.0%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>90.1%</td>
<td>88.1%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>87.1%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.2%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>78.1%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>65.6%</td>
<td>85.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From December 2016 to January 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance. From February to November 2017 rates have been above the England average.
Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Portsmouth Hospitals NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

The 11 specialties shown in the following table were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>99.9%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>99.6%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>99.2%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>96.6%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>96.6%</td>
<td>90.1%</td>
</tr>
<tr>
<td>ENT</td>
<td>96.3%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>94.7%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94.4%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Other</td>
<td>93.6%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>88.1%</td>
<td>84.1%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>87.4%</td>
<td>86.4%</td>
</tr>
</tbody>
</table>

The five specialties shown in the following table were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>90.1%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>88.4%</td>
<td>91.2%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>81.8%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>81.6%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>78.9%</td>
<td>91.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

From Q4 2016/17 to Q3 2017/18 the trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral and also better than the England average. The performance over time is shown in the graph below.
Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Portsmouth Hospitals NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

From Q4 2016/17 to Q3 2017/18 the trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The trust’s performance was also better than the England average apart from in Q2 2017/18 where it was similar. The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

From Q4 2016/17 to Q1 2017/18 the trust performed better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral and better than the England average. The trust’s performance deteriorated and from Q2 2017/18 to Q3 2017/18 the trust performed worse than the operational standard and the England average. The performance over time is shown in the graph below.
The service actively managed waiting lists to reduce delays in referral to treatment (RTT). The service had a weekly scheduled access assurance meeting for review of RTT and diagnostic performance and cancer performance. We attended this meeting and found there was discussion of business plans, mitigation of risk, staffing and recruitment, winter pressures. Root cause analysis was required when waiting list breaches. Staff carried out root cause analysis for urgent patients who have been rated exceeding 18 weeks. We saw that at the weekly scheduled access meeting managers provided an account for patients not seen in 2 plus years / 1-2 years / 1 year and six months. This meeting ensured there was a clinical oversight and mitigation of the risk of patient harm.

Staff announced delays to appointments to patients in waiting areas or delays were displayed on electronic screens.

The service collected and monitored data on delays to clinics through an electronic system. We reviewed trust data on the average delay for patients to be seen at their appointment varied between nine minutes to one hour. The average delay for most specialities was between ten and 20 minutes.

The trust did not routinely collect data on cancelled outpatient clinics. Staff we spoke with at fracture clinic told us that clinics were rarely cancelled.

In rheumatology outpatients the clinical appointment system had catch-up slots built into the day to avoid delays.

The service held virtual fracture clinic every weekday morning to minimise the time had to wait for treatment. Patients were referred from the emergency department and the virtual fracture clinic triaged and saw patients within twenty four hours. Consultants could review patient x-rays and patients can be treated with splint and advice sheet and action plan from physiotherapist.

At Gosport War Memorial outpatients we saw that at the audiology clinic patients could drop off their broken hearing aids in the morning and pick them up in the afternoon having been repaired.

Patients in ophthalmology were not always followed up and there was a concern that patients who required a follow up had been missed. We reviewed the outpatient waiting list summary report 18/04/2018 reviewed for Head & Neck CSC and found for one treatment code 41 patients were overdue for follow up appointments in the last 1 to 2 years, 152 patients overdue last 7 to 12 months, 131 patients overdue last four to 4 months, 108 overdue last 1 to 3 months. During the inspection staff were unable to show us a robust clinic plan to address overdue appointments. Following the inspection the trust submitted a plan to provide an additional eight clinics every weekend for the next six months to reduce the backlog.
The eye casualty lead described a clear escalation process for patients waiting in eye casualty to monitor four hour target.

The fracture clinic and rheumatology clinics had nurse-led advice phone lines that patients could access for support. The fracture clinic could give advice to patients over the phone so they did not need to attend clinic, for example a patient had pain and swelling and a nurse was able to give advice about footwear.

We saw information was displayed about how patients can receive appointment referral letters straight to their mobile phone.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Patients we spoke with knew how to complain to the service, if needed.

There were Patient Advice and Liaison Service (PALS) leaflets in the outpatient departments detailing how to make a complaint. Managers told us they encouraged staff to be open and honest about complaints and resolve them as soon as possible.

Senior staff we spoke with told us informal feedback from patients was encouraged and discussed at monthly meetings.

We saw from the minutes of the monthly clinical service centre clinical governance meeting that complaints were discussed.

We reviewed the trust’s response to the last three complaints and found complainants received an apology and their complaints were fully investigated. Senior staff we spoke with told us the most common complaint was about waiting times. The virtual fracture clinic had a ‘Why wait?’ poster explaining to patients the reasons for waiting times during the two hour fracture clinic appointment time.

The service encouraged feedback from patients and responded to it appropriately. We saw reception staff gave patients Friends and Family test surveys when they booked in for their appointment in rheumatology outpatients. We noted ‘You said, we did’ boards were displayed in ophthalmology and fracture clinic waiting areas.

**Summary of complaints**

From January 2017 to December 2017, there were 101 complaints about outpatients. This was the core service at the trust with the third highest number of complaints received (16.2% of trust share). The main themes were clinical treatment, communication, outpatient delay and cancellation, and attitude and behaviour. The trust took an average of 32 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 working days.

*(Source: Routine Provider Information Request (RPIR) P61 Complaints)*
Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Outpatient departments were led by clinical leads and matrons. At Queen Alexandra hospital the main outpatient area, surgical outpatients, was managed under the surgery & cancer clinical service centre. Phlebotomy, pathology, health records and the outpatient booking centre were managed by the clinical support clinical service centre. Clinical service centres were managed by a chief of service, a general manager and a head of nursing.

A senior sister was responsible for nurses working in the main surgical outpatient department at Queen Alexandra hospital and had six satellite sites including: Petersfield community hospital, Oak Park Havant, St Mary’s Health Campus, Fareham Community Hospital and Gosport War Memorial Hospital. Other clinical support centres managed their outpatient nurses at speciality level. For example, ENT and ophthalmology were managed by the head and neck clinic service unit.

Managers at the main hospital site managed nursing staff across the satellite sites. Managers told us they visited the other staff regularly. Some staff we spoke with at satellite sites confirmed this whilst others told us they did not often see managers from the main hospital site.

Most staff we spoke with thought senior leaders were visible. For example, staff in fracture clinic and surgical outpatients felt listened to and supported by senior leaders.

However staff in ophthalmology and ear nose and throat did not always feel supported or listened to by senior leaders in head and neck clinical service group.

Staff were positive about the Chief Executive of the trust. Staff told us they received weekly email updates from the chief executive and that he had visited the rheumatology outpatients department.

Vision and strategy

There was no overarching strategy for outpatient services at the trust. We requested the strategy for the service but the trust did not submit anything.

Locally, some outpatient areas had developed their own vision for the service. For example fracture clinic had developed its own vision of delivering high quality care and this was displayed on a staff noticeboard.

The senior sister for surgical outpatients told us the service was working to the NHS England priorities for outpatients.

There was no departmental strategy to meet demand in ophthalmology service.

Staff we spoke with told us demand was outstripping capacity in cardiology, renal and ophthalmology in terms of the availability of clinic rooms in which to treat patients.
Culture

There was a poor culture where staff concerns were not always taken seriously and low staff morale in some outpatient areas. However, most managers across the trust promoted a positive culture that supported and valued staff.

Staff we spoke with in phlebotomy and ophthalmology did not feel valued. Staff told us the high turnover in renal outpatients was due to issues with discrimination.

Staff described a history of bullying in the ophthalmology department where ‘behaviours were tolerated.’ The trust were aware of the cultural problems in ENT and had commissioned a study to look into the problems.

However, most other outpatient areas staff we spoke with felt supported by their immediate managers and told us they worked together to provide person-centred care.

Some staff were aware of the Freedom to Speak Up Guardian (all NHS trusts have to nominate a guardian to ensure staff can raise concerns safely) who was available for confidential advice. One staff member we spoke with gave an example of where they had raised an incident regarding another member of staff’s practice, they were listened to and the issues were addressed. However, some staff we spoke with who were aware of the Speak Up Guardian did not feel confident to raise issues with them.

Performance management and the appraisal system were used to address poor behaviours. However, some staff reported this was not always used appropriately.

Governance

There was no overarching governance structure for outpatient services. Outpatient services were managed under clinical service centres (CSCs) specific to the clinical specialities.

The outpatient booking centre and health records were managed under the clinical support CSC.

Most outpatient staff attended a speciality level team meeting where they could escalate any concerns. Ward level meetings escalated up to the speciality level CSC monthly governance meetings. Surgical outpatients had introduced a morning huddle to update staff on the work plan for the day and any clinical issues. Outpatient nursing staff in medical specialities attended ward level meetings. Staff in renal outpatients told us team meetings did not always go ahead and they had not had a team meeting for 18 months.

In the eye department there was a monthly governance and business assurance meeting that escalated issues up to the head and neck CSC governance meeting. This meeting had a set agenda and we saw that incidents, the risk register, infection control and mandatory training compliance were discussed.

We reviewed meeting minutes for the past six months for a sample of three different CSC monthly governance meetings. We found that renal & transplant and head & neck CSC had standard agendas that included: review of incidents, risk register, mandatory training compliance. The muscular skeletal (MSK) clinical governance meeting did not have a standard agenda although we saw that the risk register and incidents were discussed at the meeting there was a risk that other areas of governance were not discussed.

Staff we spoke with understood their roles, what they were accountable for and who they reported to.
Management of risk, issues and performance

Although the trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. We found that not all risks identified by staff were on the risk register.

Managers we spoke with had oversight of the risks within their department. These risks were generally understood by staff and included: increasing demand on services and capacity in clinics, IT systems and availability of scopes in surgical outpatients. However, in some departments we were concerned about a lack of action to mitigate risks identified at a local level.

We reviewed the risk register for outpatients and found that it reflected most of the risks staff had told us about and appropriate controls to mitigate the risks identified. However, the size of the ophthalmology outpatient waiting list, out-dated equipment in the eye department and the risk that staff in eye casualty were working in a very isolated area of the hospital with few staff working at weekends were not reflected in the risk register. Senior staff we spoke with were concerned that there was a lack of action to address risks they had identified to the head & neck management clinical service centre (CSC) management team.

We saw from CSC governance meeting minutes that risk registers were reviewed every month.

We were not assured of the trust’s management of the environmental and fire risk of the ophthalmology department. We requested fire and environmental risk assessments for the department and the trust responded. A risk relating to ‘lack of space to accept stretcher patients in eye outpatients’ was opened in November 2016 and last reviewed November 2017 the risk was rated as moderate.

The director of nursing for the Ear, Nose and Throat Clinical Service Group had put the ophthalmology on an intensive support programme. Key areas for improvement were serious incidents, waiting list backlog, and workforce planning.

The trust held a weekly scheduled access assurance to review referral to treatment times and the cancer pathway. The meeting was attended by managers from the different CSCs. During inspection we attended the scheduled access assurance meeting chaired by the department chief operating officer. The meeting had a set agenda and an action log. We saw that overall capacity issues were discussed and details of specific patients who had waited over 35 weeks. Root cause analysis was presented for long waiters and we saw there was challenge around urgent patients who were booked in over the 18 week target. We reviewed the meeting minutes of the last three weekly scheduled access assurance and saw that high risk patients who had waited over 35 weeks were discussed.

Information management

The trust collected, analysed and used information well to support all its activities, using secure electronic systems with security safeguards.

The health records manager attended a monthly information governance and data quality meeting. There was no strategy for moving towards paper light records. Staff in the urology department had trialled the use of paper light records.

We saw that information governance issues and compliance was a standard agenda item on the renal and transplant clinical service centre governance meeting.
Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage services appropriately.

The service did not carry out any additional service-wide outpatient surveys other than the Friends and Family test. Some outpatient departments carried out additional local surveys. For example, the Wessex Renal Centre encouraged patient feedback through a kidney transplant aftercare patient questionnaire.

Respiratory patients had the opportunity to get involved in respiratory research to access new treatments and help develop better care.

At the fracture clinic on the main site and Fareham community hospital outpatients staff were aware of the trust wide ‘learning into action’ programme. The trust invited staff to get involved with their ideas for improving services.

The trust had a staff recognition scheme for all staff. Two plaster technicians had been recognised in the scheme for ‘going the extra mile’ when assisting in the emergency department they supported a patient with a foot fracture by fitting a lightweight plaster cast so they could return home sooner.

Staff in most specialities attended monthly staff meetings. At the Macmillan cancer centre staff meeting minutes displayed on noticeboard and in the ENT department monthly team meeting ideas for the next staff meeting were displayed on the back of the office. However, staff in ophthalmology were not released from duties to have a staff meeting and had to hold a staff meeting during staff lunch breaks. This resulted in low attendance and had a negative impact on staff morale. Staff in renal outpatients told us they hadn’t had a team meeting in 18 months.

The clinical support CSC engaged with staff through a monthly newsletter to teams and a weekly message to share good practice.

Some staff were aware of the planned changes to the clinical service centre structure but the trust had not formally engaged staff about these changes at the time of the inspection.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. Staff we spoke with told us they had opportunities to access further training.

Staff were able to give examples of innovative work going on in their department. For example a new hepatology clinic.

Some outpatient departments were doing innovative work. For example, the dermatology service had introduced a tele dermatology service to reduce waiting times and improve patient satisfaction. Patients could be referred from the GP to the medical photography service to aid triage of the patient into an urgent 2 week wait appointment in dermatology, or advice to the GP for primary care management.
The Portsmouth NHS Trust provides a wide range of diagnostic imaging services, principally at its Queen Alexandra Hospital site based in Cosham, Hampshire.

These services include:
- X-rays
- Computed Tomography (CT) scanning
- Magnetic Resonance Imaging (MRI)
- Ultrasound
- Nuclear medicines
- Screening/Fluoroscopy
- Interventional radiology
- Mammography
- Cardiac catheterisation laboratories (managed by Cardiology)

The trust also offered services at three other trust hospitals, these include:
- Gosport War Memorial Hospital
- Fareham Community Hospital
- Petersfield Community Hospital

Portsmouth Hospitals NHS Trust provides District General Hospital services to a local population of 675,000 across South East Hampshire, and additionally some tertiary services to a wider catchment in excess of two million people.

The Queen Alexandra Hospital site includes 1200 beds including cots, 28 theatres, two purpose built interventional radiology suites, two fluoroscopy, three MRI scanners and three CT scanners. They also have six digital x-ray rooms in the main department; two digital x-ray rooms in the radiology day case unit (a nine bedded unit for in-patients); two digital x-rays and an ultrasound room in the paediatric department; 12 ultrasound scanning rooms; three digital x-ray rooms which included a dedicated paediatric room in the emergency department; and six digital MobileDaRT machines (a mobile X-ray system) and three digital mammography rooms with a mobile screening unit. The trust also has pathology laboratories and critical care facilities.

During our inspection we spoke with 45 members of staff including the deputy medical director, radiology service leads, imaging services manager, radiographers radiologists, sonographers, student radiographers, radiography assistants, radiation protection advisor and the head of the imaging physics group.

We spoke with four patients and two relatives asking for their experiences when using the diagnostic imaging services, reviewed ten patient care records, reviewed policies and procedures as well as documents relating to the running of the diagnostic imaging services including the risk register. We also asked the trust to provide information regarding customer feedback and reviewed analysis of ‘Comments, complaints and concerns’ feedback slips which had been gathered within the diagnostic imaging departments.

We inspected nine different departments across four hospitals, Queen Alexandra, Fareham, Petersfield and Gosport War Memorial Hospital, assessing their design, safety and ability to meet patients’ needs. During the inspection we were present throughout a number of pre, during and post imaging interactions between staff and patients.
This was an announced inspection. The trust was given four weeks’ notice of our inspection to ensure key staff were available to be spoken with. During this inspection we reviewed the following five key questions;

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?, and
- Is the service well led?

The service was previously inspected in July 2017 where failings were found within the X-ray department at Queen Alexandra Hospital (QAH). The inspection did not result in a rating being provided to the trust, however the failings identified were found to warrant the imposition of conditions upon the trusts conditions. These conditions and whether or not the provider was meeting these was reviewed as part of this inspection. The conditions included;

- The Registered Provider must take evidenced based appropriate steps to resolve the backlog of radiology reporting using appropriately trained members of staff. This must include a clinical review, audit and prioritisation of the current backlog of unreported images, (including those taken before January 2017); assess impact of harm to patients, and apply Duty of Candour to any patient adversely affected.
- The Registered Provider must ensure they have robust processes to ensure any images taken are reported and risk assessed in line with Trust policy.

The inspection team consisted of a lead inspector, an inspector and a specialist advisor (diagnostic radiographer).
Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

The provider set a target of 85% completion of mandatory training with the exception of information governance where the trust completion target was 95%.

Nursing/Midwifery staff within the service achieved an overall completion rate for 90%. The service met the completion target for 12 of the 16 courses made available to nursing staff with 10 of these having a 100% completion rate. The service, however, failed to meet the target for four modules including adult basic life support and conflict resolution.

**Mandatory training subjects and completion rates for nursing and midwifery staff within the service.**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>10</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
For medical and dental staff in the service the overall completion rate for medical staff was 88%. This exceeded the trusts completion target for 10 of the 14 courses available for staff. The service however, failed to meet the target for four modules which included conflict resolution which had a completion rate of 37%. Staff we spoke with were confident, despite not receiving recent training in these four subject areas they knew, and could describe to the inspection team appropriate action to take when facing these circumstances.

**Mandatory training subjects and completion rates for medical and dental staff working within the service.**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>45</td>
<td>46</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>45</td>
<td>46</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>45</td>
<td>46</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Incident Reporting</td>
<td>45</td>
<td>46</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>43</td>
<td>46</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>43</td>
<td>46</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>43</td>
<td>46</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>42</td>
<td>45</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Bullying and Harassment Awareness</td>
<td>42</td>
<td>46</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>35</td>
<td>46</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>34</td>
<td>46</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>17</td>
<td>46</td>
<td>37%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The service provided mandatory training in key skills to all staff. However, compliance was not always in line with the trust target. Despite this staff we spoke with evidenced knowledge and confidence in managing these training areas including conflict resolution and life support.

**Safeguarding**

Staff understood their role in identifying and reporting safeguarding concerns to keep patients safe.
Staff had mostly met the trusts target for the 85% for the completion of safeguarding training.

A breakdown of compliance for safeguarding courses between April 2017 to January 2017 for nursing and midwifery staff in the service is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in the service had achieved a 100% completion rate in two of the three modules required by the trust however, had not completed safeguarding level two training in line with the trust’s completion target. Staff, however were able to demonstrate they knew how to recognise, report and manage safeguarding concerns for both adults and children. This included the correct internal and external bodies to raise such concerns.

A breakdown of compliance for safeguarding course between April 2017 and January 2018 for medical/dental staff in the service is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>45</td>
<td>46</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>45</td>
<td>46</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>43</td>
<td>46</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff in the service exceeded the trust’s target of 85% completion of all three modules of safeguarding training.
Staff understood how to protect patients from abuse. The provider had a ‘Safeguarding Vulnerable Adults, Children and Young People’ policy in place which provided guidance and support to staff on how and when to raise a concern.

Although due to their infrequent and brief contact with the patients, staff reported they had not experienced escalating any concerns but were aware of the action they would take if required to do so.

The intercollegiate document ‘Safeguarding children – Roles and Competencies for Healthcare Staff’ published by the Royal College of Paediatrics and Child Health 2014, states, ‘All clinical staff working with children, young people and/or their parents/carers, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person; where there are safeguarding/child protection concerns’, should be trained in safeguarding for children level one, two and three. The reporting radiologist was trained to safeguarding children level three and was available to support staff whenever required with advice and support. An additional two radiologists were also in the process of receiving their safeguarding children level three training to improve resilience in staff knowledge.

To safeguard patients against experiencing the wrong investigation patients were called into the departments and asked to confirm their identity by providing their full name, date of birth and first line of their address. The Society of Radiographers (SoR) “pause and check” system was used across all areas with posters displayed. Pause and check refers to the SoR operator checklist which prompts radiographers to confirm the patient and the investigation using the prompts below:
| **P** | **Patient** | Check the exam is justified  
Check the examination history for recent studied and duplication  
**Confirm patient ID, always use unique identifiers**  
Confirm pregnancy status  
Confirm the patient expected the exam  
Confirm the patient has not had a similar exam recently |
| **A** | **Anatomy** | Select the correct anatomical area  
Select the correct laterality  
Place the correct anatomical marker within the primary beam |
| **U** | **User Checks** | Confirm the exam is being completed at the right date and time  
Confirm the exposure has been authorised  
Confirm the correct modality  
Check radiation safety measures for staff and/or carers  
Communicate appropriate instructions to patient, carer and team |
| **S** | **Systems and settings** | Select correct patient (unique ID) and exam date/time  
Select correct imaging protocol/technique  
Select optimal exposure factors (and adjust if required)  
Select correct detector |
| **E** | **Exposure** | Confirm there is no clinical reason this exposure should not proceed  
Expose  
Record dose and reference diagnostic reference level (DRL)  
Evaluate images, confirm necessity for repeat or additional views |
| **D** | **Draw to a close** | Add image comments or flags as appropriate  
Complete radiology information system (RIS) record  
Confirm picture archive and communication system (PACS) images are stored correctly  
Tell patient how to get results and where to go next |

(Source: The Society of Radiographers)
Cleanliness, infection control and hygiene

The service controlled infection risks well. Staff kept themselves, equipment and the premises clean. Control measures to prevent the spread of infection were available and practiced by staff, patients and visitors. Patients and relatives visiting the departments were routinely asked to sanitise their hands.

The majority of staff had received training on infection prevention and control, exceeding the trust’s target of 85% with 100% of nursing and midwifery staff completing and 93% of medical and dental staff within diagnostics completing.

Staff said when treating patients who had a communicable infection such as TB, flu or scabies, all attempts were made to ensure their investigation was prioritised to reduce time spent with other patients. Where possible, appointments were booked for quieter times within the departments. Patient times in treatment rooms were minimised to reduce the risks of cross infection. After their investigation staff sought immediate support from an external cleaning team. The external cleaning team took responsibility to deep clean the environment and staff told us they were happy with their response times.

Environment cleaning was provided by an external company and was completed at regular intervals. We saw daily cleaning schedules were completed and up-to-date. Departmental staff were happy with the level of service they received. In-between patients staff were responsible for cleaning equipment and we saw this was completed thoroughly using disinfectant wipes.

We found clinical and patient waiting areas were visibly clean and free from dust and debris. There were cleaning schedules in place and we saw staff clean equipment at the start of each day and in-between patient use using sanitising wipes for surfaces and equipment.

We observed safe hand hygiene practices were followed to minimise the risk of cross infection between patients. Posters in waiting areas and other communal areas advised patients and visitors to disinfect their hands using cleaning products provided. Hand sanitiser units were located throughout the department and staff consistently used these as they left and re-entered treatment rooms. All staff we observed in clinical areas were ‘bare below the elbow’ in accordance with the national institute for health and care excellence (NICE) guidance. There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers available for use and being used.

The trust provided a hygiene audit undertaken taken across the Queen Alexandra Hospital (QAH) in April 2018. This identified whether staff were bare below the elbow, had clean nails, wore appropriate protective equipment and followed safe hand hygiene practices. This audit showed the diagnostic imaging departments at QAH had achieved 100% compliance with all areas audited, evidencing safe infection control practices.

Equipment such as probes used for intimate investigations were appropriately cleaned and stored. The trust had two specialised cabinets on loan, which were used to disinfect these probes to ensure they remained available for patient use. These had been identified as beneficial pieces to reduce the risk of cross infection. The equipment allowed for faster, more efficient cleaning with a documented process identifying when they had used and cleaned. A business case was being proposed to purchase these items so they remained within the trust.

Within the children’s x-ray and ultrasound reception area were a number of children’s toys and books available. Upon visual inspection the toys appeared clean, staff however, provided differing information regarding how their cleanliness was maintained. Some staff said they
cleaned toys with sanitising wipes whilst other staff said they made a disinfectant solution to clean items. A daily cleaning schedule for these items was in place and we could see they were suitably cleaned and appropriate for use however, we asked for evidence of guidance provided to staff on the best way to manage infection prevention control risks concerning children’s’ toys but staff were unable to provide this.

Environment and equipment

The service had suitable premises and equipment which was maintained to ensure it remained safe for use.

Resuscitation equipment was observed to be in good working order and checked regularly for fitness of use. Staff completed daily checks which were documented to evidence their completion. The resuscitation equipment for the children’s x-ray and ultrasound department however was not kept in a way to afford immediate access. The equipment was situated through a set of double doors, along a corridor and through a secondary set of double doors. Staff said they would not treat children experiencing a health decline in the department as this could potentially place them at risk of not being able to receive immediate lifesaving care. In these instances mobile imaging equipment would be taken to the child to minimise the risk to their health.

Diagnostic services were located across the QAH hospital. There was an X-ray department designated for the use of patients within the emergency department (ED). The Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) area were situated on the same level as ED to enable timely access to scanning. Inpatient and outpatient x-rays, ultrasound, fluoroscopy, paediatric department, mammography and nuclear medicine departments were located on other levels within different parts of the hospital.

All departments were signposted from the hospital main entrance; however, it was not always clear for patients moving between services the direction and lift required in order to reach any secondary destination. We observed all hospital staff offering patients and visitors directions to where relevant departments were and were able to give clear directions when asked.

When arriving in the X-ray and scanning department, patients faced a reception desk where they registered for their investigations. Patients were asked to wait in the designated waiting room until they were called through to the relevant modality area.

Waiting areas were clear of clutter with suitable numbers of chairs available to meet patients’ needs. Televisions and magazines were located in main waiting areas to help occupy patients whilst awaiting their appointments. These areas were clean with fresh water available and patient notice boards displaying health promotion information.

Patients attending for a CT or MRI appointment were directed to sub waiting areas where they would wait staff attendance. This afforded additional privacy for patients who may have been required to change into hospital gowns prior to their investigation. Entrance into the relevant departments did not always have restricted access however access to treatment rooms was restricted.

The environment in the children’s diagnostic area was designed and decorated to be suitable for children. Sea side themed mobiles hung from the ceiling to provide interest, a television continuously showed children’s programmes and there were toys available including a computer gaming system, puzzles and books available. Seating was available in both adult and child sizes to ensure patients individual needs were met.
All imaging rooms were clearly signposted with “Do Not Enter” warning lights to ensure staff or patients did not enter rooms whilst imaging was taking place. Each treatment room had details of what activity was performed in each room clearly attached to the doors (local rules). MRI equipment and devices were clearly labelled, this was in accordance with Medicines and Healthcare Products Regulatory Agency 2015 recommendations. Rooms were clearly identifiable and controlled areas highlighted. We saw patients were escorted to the x-ray room or adjacent waiting areas, prior to their investigation. This helped to reduce the risk of patients or visitors walking into restricted areas.

Staff wore lead aprons where appropriate which were screened annually to ensure they were not damaged. Staff also wore radiation exposure devices which were analysed every three months to ensure staff were not over exposed. Staff working within nuclear medicine were subject to daily review of radiation levels of their hands and shoes to ensure exposure levels were within acceptable ranges.

A dose reference level chart was available on the wall within the CT department which identified between January 2015 and January 2018 auditing had been completed to ensure dosages provided to patients during investigations were within acceptable levels.

We saw evidence of quality assurance testing of equipment was completed at regular intervals in line with the Institute of Physics and Medical Engineering. This work was undertaken by the medical physics team supported by radiographers and included generator checks and lightbox alignment every two months for example.

There was a formal capital rolling replacement programme for equipment. This included details on the year the equipment was purchased, expected date for replacement, details of the use and any recommendations according to the level of risk presented should an item fail. Equipment within the Hospital was under a service level agreement for maintenance and replacement with an external provider.

Staff appropriately segregated waste products into hazardous and general waste bags. Bins were not overfilled and regularly removed from the departments. Most sharps bins were assembled correctly and safely used. One sharps bin in the CT contrast imaging preparation area however, was not used appropriately. The bin opening was not restricted affording access to the contents within. All sharps bins however were labelled with date of assembly and signed by the relevant staff member. Nuclear medicines were managed safely with security measures in place to ensure they were stored and disposed of appropriately.

Cleaning materials were stored securely in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation which requires employers to control substances which are hazardous to health.

The service had 24 hour support for their Picture Archiving and Communication System (PACS) which was the system used to store patient images. In the event of a PACS failure this would significantly impact on service availability. Staff told us there were staff available who were responsive when required.

There was a 24 hour helpline which was used to provide assistance with equipment failure. Staff were able to access the number from the intranet and signs were placed around staff areas. During the inspection a piece of equipment became unavailable due to a failed part. Staff took immediate action to contact the relevant parties to arrange for replacement parts to be delivered as soon as possible. Staff told us when equipment was no longer available for use they would still be able to prioritise investigation for those who required it. In the event of widespread CT failure
an agreement was in place with a neighbouring NHS trust to ensure acute and emergency patients would still receive the investigation they required.

Assessing and responding to patient risk

The service assessed their performance against targets to identify performance and patient risk. The service used information to improve the service.

We saw risk assessments in place for patients and staff using the service. These were based on national guidance and updated at regular intervals according to any changes in national guidance. We saw risk assessments were generally kept electronically and easily accessible to staff.

The department had a full set of Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R procedures and standard operating procedures as required under the Regulations. The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 1999 (IRR99). Local rules as required under IRR99 were evidenced throughout the department. All areas which utilise medical radiation in hospitals are required to have written and displayed local rules which set out a framework of work instructions for staff.

Staff told us what action they would take if a patient became unwell or distressed while waiting for, or during, investigation. The action taken depended on the specific situation and staff provided examples which showed they would take appropriate action. This included managing the health of a deteriorating patient. We saw a patient experience a health decline whilst waiting for investigation within the CT area. This was responded to swiftly by staff with appropriate action taken to manage the patient’s health and distress.

A screening process was in place which enabled radiographers to identify any pre-existing clinical conditions which may impact on the ability to perform an investigation. For example, patients with an impaired kidney function received a reduced dose of contrast media. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. Staff checked patients, who required a contrast media, were not allergic to any substances prior to administering the medicine. During the inspection staff routinely asked a patient to confirm their previous medical history. For one patient this identified they were not suitable for the planned MRI and staff sought alternative investigative options which would provide the required information in a safe way.

Patients from the Emergency Department (ED) were accompanied by a member of staff to the CT and MRI scanning departments. This was to ensure where patients were not able to clearly communicate their needs the staff member would be able to convey the investigation required as documented in their notes. Staff told us however, inpatients attending from any other department were not always accompanied either by a porter or a member of staff. As a result staff would not always receive detailed patient’s care notes which would document what pre-existing health decisions a patient had in place. For example, staff told us of one patient who had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place. This patient had been transferred to their department without staff being made aware of this order. Staff later identified this was in place once they had left the department. If the patient had suffered a radical health decline whilst being treated there was a risk they would have received medical treatment which was against their wishes. We did not identify during the inspection if this had been raised as an incident by staff to ensure learning was shared to mitigate the risk of this being repeated.

The service had designated and clearly identifiable radiation protection supervisors (RPS) available to provide guidance and support to staff. Their details were publicised on treatment
room doors. The trust’s radiation protection advisor (RPA) was also at QAH and available to provide guidance and support. Staff, including those working in community settings, reported all these staff members were accessible and responsive to their needs.

Patients were referred to the departments by a number of methods, including via the patients’ GPs or consultants. On receipt of the referral the request was screened for appropriateness to ensure the right investigation was being requested according to the patient’s complaint. If there were any concerns about the requested treatment, the screening radiologist would contact the referrer to discuss alternatives.

There was a robust process for the assessment of patients who may be pregnant. Posters, in all waiting areas, asked patients to talk to staff if they suspected they may be pregnant. These posters contained information translated into 15 languages to ensure all patients were able to understand. A checklist was used to assess any potentially pregnant patient prior to the investigation being completed and patients were asked to confirm, sign and date they were not pregnant.

Patients attending nuclear medicine had a segregated waiting area from other departments in QAH. Access to the department was limited for children and patient’s relatives to ensure any risk of exposure to radioactive substances were minimised.

Staff were able to deal with patients who could express challenging behaviour. During the inspection staff identified an inpatient was experiencing confusion which made them unable to cooperate with positioning prior to the treatment. This meant staff were unable to complete their planned investigation. To minimise the risk of escalating behaviour the patient was returned to the ward and rescheduled for x-ray two hours later in the day. Upon their return they were calm and complied fully with staff instructions enabling them to complete the required investigation.

Patients were asked to confirm their identity prior to an investigation being completed. Information relating to the patients name, address, date of birth and expected investigation technique was discussed between the patient and the member of staff on arrival to the department. Patients who were unable to confirm their identity were referred back to the requesting clinician. Staff told us if a patient was unable to confirm their identity they would not complete the requested investigation. If the patient wore an identity bracelet, the patient’s identity would be confirmed against this and if inpatients were accompanied by a member of staff to the relevant departments they would also be asked to confirm the correct patient had been brought for investigation.

We saw there were processes in place to ensure the right person received the right investigation. The service had robust standard operating procedures which reflected best practice. The service used a ‘hot’ reporting radiographer within the emergency department. They were used to offer immediate reporting of images obtained of a patient’s limbs where a break or fracture was suspected. This allowed the patient to receive a timely report on their image and for the correct treatment plan to be put in place by the relevant medical team.

There was a system in place to ensure generator testing or IT network shutdown/ testing did not impact on patient safety. Staff were involved in discussions regarding the planning and timetable of work which may affect the network. Outages would not occur without the service’s knowledge and could be cancelled at any time during such testing if a patient’s needs were urgent.

The overall radiation protection was managed by an internal team. Staff reported this service was accessible and responsive to their needs. The team provided radiation protection training and support to the RPSs within the department.
The diagnostic department had a number of methods of taking an image, classed as modalities, which included X-rays, CT, MRI and Ultrasound. There were two waiting periods involved with imaging investigations, the first being the wait for the investigation (image) to be completed and the second the time for the image to be interpreted by a radiologist (termed reported). In some cases, the trust judged it adequate for an image to be interpreted by a non-radiologist clinician, which is termed as “reviewing”. Patient’s treatment often relies on the reporting of an image by the radiologist to the patient’s clinician.

In July 2017, we identified there were 11,722 chest x-ray images waiting for radiology reporting, including some routine outpatient, but mostly emergency department plain films. Inpatient films were not included as they are reported by the clinician responsible for the patient, but they were not reported on by a radiologist.

The trust was issued with enforcement action in July 2017 in response to this significant backlog of unreported chest x-rays. Following this, a management strategy was implemented, which included an audit of all unreported plain films and the decision the service should report all chest x-rays contemporaneously. The service devised an action plan which included the outsourcing of reporting to reduce the backlog and provide prospective reporting review of staffing, recruitment to vacancies and a review of standards.

Following enforcement action the trust implemented the procedure where all Emergency Department x-rays would be reported by radiology which would minimise the risk of a backlog of x-rays developing. The trust had two radiographers who were in the process of training as chest reporting radiographers at the time of the inspection. The trust had agreed to the further recruitment of an additional two reporting radiographers to support staff with the review of all x-rays. At this inspection it was identified all images had been reported by the end of February 2018.

Harm reviews had been completed to identify if harm had occurred to any patient as a result of a delay in reporting and five cases had been identified where the delay in reporting potentially impacted on a diagnosis. At the time of this inspection work was ongoing to fully investigate these cases and ensure duty of candour was applied with each patient identified as affected.

**Staffing**

**The service had enough staff with the right qualifications and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment.**

**Nurse Staffing**

The trust has reported their staffing numbers in the below table for nursing staff in the service from April 2017 to March 2018.

Fill rates ranged between 92.1% to 109.6% during the period. As of March 2018, there were similar whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care; this was due to maternity cover.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>8.7</td>
<td>8.9</td>
<td>102.3%</td>
</tr>
<tr>
<td>May</td>
<td>9.2</td>
<td>8.9</td>
<td>96.7%</td>
</tr>
<tr>
<td>Month</td>
<td>Vacancy Rate</td>
<td>Turnover Rate</td>
<td>Agency Staff Usage</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>June</td>
<td>9.2</td>
<td>8.9</td>
<td>96.7%</td>
</tr>
<tr>
<td>July</td>
<td>9.2</td>
<td>8.9</td>
<td>96.7%</td>
</tr>
<tr>
<td>August</td>
<td>9.2</td>
<td>8.9</td>
<td>96.7%</td>
</tr>
<tr>
<td>September</td>
<td>9.2</td>
<td>8.6</td>
<td>93.9%</td>
</tr>
<tr>
<td>October</td>
<td>9.2</td>
<td>10.0</td>
<td>109.6%</td>
</tr>
<tr>
<td>November</td>
<td>9.2</td>
<td>9.4</td>
<td>103.1%</td>
</tr>
<tr>
<td>December</td>
<td>9.2</td>
<td>8.4</td>
<td>92.1%</td>
</tr>
<tr>
<td>January</td>
<td>9.2</td>
<td>9.2</td>
<td>100.0%</td>
</tr>
<tr>
<td>February</td>
<td>9.2</td>
<td>8.9</td>
<td>97.4%</td>
</tr>
<tr>
<td>March</td>
<td>9.2</td>
<td>8.9</td>
<td>97.4%</td>
</tr>
</tbody>
</table>

(Source: updated figures provided by the Trust following the inspection)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From January 2017 to December 2017 the trust reported an annual over-establishment of 0.7% for qualified nursing staff in the service.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

In December 2017 the trust reported a turnover rate of 13.8% for qualified nursing staff in the service which is above the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

The trust has reported their staffing numbers below for medical staff from April 2017 to March 2018.

Fill rates ranged between 84.0% to 95.5% during the period. As of March 2018, there were 7.6 fewer whole time equivalent (WTE) staff in post than the trust planned to provide safe and effective care.
<table>
<thead>
<tr>
<th>Month</th>
<th>WTE planned staff</th>
<th>WTE actual in post</th>
<th>Fill rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>44.9</td>
<td>40.7</td>
<td>90.7%</td>
</tr>
<tr>
<td>May</td>
<td>44.9</td>
<td>40.7</td>
<td>90.8%</td>
</tr>
<tr>
<td>June</td>
<td>44.9</td>
<td>40.7</td>
<td>90.8%</td>
</tr>
<tr>
<td>July</td>
<td>44.9</td>
<td>40.8</td>
<td>91.0%</td>
</tr>
<tr>
<td>August</td>
<td>44.9</td>
<td>42.8</td>
<td>95.5%</td>
</tr>
<tr>
<td>September</td>
<td>47.4</td>
<td>42.8</td>
<td>90.3%</td>
</tr>
<tr>
<td>October</td>
<td>47.4</td>
<td>42.8</td>
<td>90.3%</td>
</tr>
<tr>
<td>November</td>
<td>47.4</td>
<td>42.8</td>
<td>90.3%</td>
</tr>
<tr>
<td>December</td>
<td>47.4</td>
<td>42.8</td>
<td>90.3%</td>
</tr>
<tr>
<td>January</td>
<td>47.4</td>
<td>42.8</td>
<td>90.3%</td>
</tr>
<tr>
<td>February</td>
<td>47.4</td>
<td>42.8</td>
<td>90.3%</td>
</tr>
<tr>
<td>March</td>
<td>47.4</td>
<td>39.8</td>
<td>84.0%</td>
</tr>
</tbody>
</table>

(Source: updated figures provided by the Trust following the inspection)

In December 2017 the trust reported a turnover rate of 3.1% for medical and dental staff in the service which is below the trust’s turnover target rate of 10.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The trust was unable to provide the appropriate data. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Following the inspection we asked the trust to provide details of bank and agency staff used within the different modalities in the month of April 2018.

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>ROLE</th>
<th>Time required (April 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
<td>Radiographer</td>
<td>150 hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>Radiographer</td>
<td>60 hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>RDA</td>
<td>22.5 hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>RDA</td>
<td>73.5 hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>RDA</td>
<td>22.5 hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>RDA</td>
<td>4 hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>RDA</td>
<td>7.5 hours</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>Not provided</td>
<td>Required from 9 April</td>
</tr>
<tr>
<td>Breast screening</td>
<td>Not provided</td>
<td>Mondays when required</td>
</tr>
<tr>
<td>Breast screening</td>
<td>Not provided</td>
<td>1 week in four</td>
</tr>
<tr>
<td>Service</td>
<td>Role</td>
<td>Hours per week</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Breast screening</td>
<td>Not provided</td>
<td>40 hours per week</td>
</tr>
<tr>
<td>Oncology</td>
<td>Not provided</td>
<td>40 hours per week</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Sonographer</td>
<td>Not provided</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>RDA</td>
<td>Not provided</td>
</tr>
</tbody>
</table>

The trust provided March 2018 figures for MRI and CT agency staff usage. Staff roles were not provided so we were unable to comment on the types of roles which required recruitment.

This showed for March 2018, on average, three shifts per day required the use of agency staff to continue to offer patient investigations.

Senior staff acknowledged the need for recruitment into specialist areas to reduce the use of specialist agency staff. The trust had recognised the need for additional staff and had made money available for recruitment and retention. A national shortage of trained staff however, had made this difficult. The trust reported of 57 commissioned places for training to become a radiographer only 45 students had applied and were studying. To mitigate the risk of staffing shortfalls the trust used regular agency staff to support the service and were looking at upskilling existing staff members providing extra training to enable them to complete additional roles which would reduce staff agency usage.

The service had a range of student, newly qualified and senior radiographers within each business unit. We saw there was an experienced radiographer in each department which ensured less experienced staff were supported. Staff were also able to contact the clinical leads for further assistance if necessary. We saw staff discussed staffing levels and activity with the clinical leads to ensure safe cover across all departments.

Staff told us there were never any issues contacting a radiologist who was able to remotely review images. This allowed them to offer remote advice and identify when it would be necessary to attend the hospital to provide staff with additional support.

Rotas were completed by each modality with some staff receiving their shifts working patterns 16 or 24 weeks in advance. Staff told us they felt this helped with recruitment and retention of staff as they knew where and when they were working in advance. Staff said this also assisted them in identifying where extra support was required and enabled them to backfill to cover any identified short staffed shifts.

We saw a minuted handover process called ‘safety huddles’ where staff discussed workload and planned activity at the start of each duty. Patients were also discussed as they were added onto the day’s activity list. Staff then completed a ‘safety huddle’ at the end of the day which enabled to staff to share any concerns from the days’ activity. This also allowed staff to work together to finish outstanding work so they all finished together which staff felt was positive for staff morale.

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

The service used two electronic record systems. The computerised radiology information system (CRIS) and PACS. CRIS was a password protected record of patient’s demographics and could be used to book patients into vacant investigation slots. PACS was the system for storing completed images and the associated reports. This system was also password protected and accessible only to radiology staff for reporting and clinicians who had requested the image.
The service maintained comprehensive written patient records, with details of all investigations and their findings electronically on PACS.

All computers observed were password protected and locked when not in use. We saw computers were generally not in patient areas, but those which were, were turned to prevent patients reading confidential information.

Patient records contained additional information to inform staff if a patient required additional support whilst under investigation. This included highlighting to staff if the patient had mobility issues, or presented an infection risk for example, all of which may hinder patient’s ability to receive an investigation without additional support. This information was reviewed at the point of investigation by a radiographer who signed and confirmed to evidence they had read the information.

Referrals to the service for X-rays were completed in two different ways, by paper referral or by electronic referral. The service was addressing the referral process in an aim to standardise the process used. We were told the service was planning to “go paperless” which would allow for faster referral access and minimise the time it took in the emergency department in particular to walk to and from the relevant departments.

Throughout all departments, care was taken to ensure computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use. There was a clear standard operating procedure for staff to follow in the event of IT failure.

**Medicines**

The service had robust processes in place to ensure when medicines were used they were ordered, delivered, stored and disposed in a safe way. Systems were in place to ensure the right patients received the right medication at the right time by the right route.

The administration of contrast media and specific medicines in MRI and CT was cited as being via patient group directives (PGD). A PGD is a written instruction for the supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs allow specific health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing the patient fits the criteria as identified in the PGD. This meant radiographers were able to administer identified medicines, such as painkillers, for specific investigations. PGDs viewed were in date and approved according to the area they covered. Staff had signed these to evidence they had received relevant training and were competent in order to meet the conditions identified in the PGD.

We saw medicines and treatment rooms were securely locked with access keys restricted to identified staff only. Staff maintained possession of medicine storage keys during their working hours and then returned them to a key safe when no longer required. Treatment rooms were well organised with dedicated cupboards for the storage of medicines. Staff maintained a record of medicines being stored and used. Contrast media was safely stored and accessible only by authorised members of staff.

Nuclear medicine used the administration of radioactive substances advisory committees (ARSAC) diagnostic reference level charts which were signed by the certified ARSAC holder. The dose radiopharmaceuticals (medicines used) was calculated according to the procedure being completed and provided by a neighbouring NHS Trust hospital on a daily basis according
to the patients attending the department. This meant there was minimal wastage. We were told if a patient did not attend for the appointment, the additional medicine would be used to perform quality assurance testing or stored safely until it was safe to dispose of. ARSAC records were completed fully accurately evidencing correct documentation of the information required. The nuclear medicines department had clearly identified rooms which were used for the preparation, storage and disposal of nuclear medicines which was clearly signposted.

Care was taken to ensure the right patient received the right medicine. A patient’s identity was checked, confirmed and then checked against their prescriptions. Patients did not wear identity bracelets when visiting the department as an outpatient, however, inpatients were expected to wear ID bracelets throughout their admission. Patients who were unable to confirm their ID did not undergo the procedure and were referred back to the requesting clinician. Staff, however, told us this rarely occurred.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in diagnostics (Radiology) both at Queen Alexandra Hospital which met the reporting criteria set by NHS England from February 2017 to January 2018.

These were:

- One slip/trip/fall meeting SI criteria (April 2017)
- One diagnostic incident including delay meeting SI criteria (including failure to act on test results) (May 2017)

(Source: Strategic Executive Information System (STEIS))

We reviewed the investigations into these incidents. These showed the investigations had been detailed in their completion reviewing all care provided to both patients with lessons learned and action taken, where available, to minimise the risk of reoccurrence.

No radiation incidents had been reported under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) since the last inspection.

Staff were aware of their roles and responsibilities for reporting safety incidents and near misses internally and externally. Staff told us they were encouraged to report incidents and were able to complete this on the trust’s electronic reporting system. For example, staff told us by using this process they had identified a piece of equipment in use, which had been placing patients at risk of elevated medical exposure. Additional work was completed which resulted in a change of working practice to keep patients’ safe.

Staff told us lessons learnt and actions taken as a result of investigations were shared across the team. Bands five, six and seven staff had separate meetings where such incidents were discussed. Messages were also cascaded to staff from the executive board via email. In the event of staff being on leave at the time learning was disseminated all staff were clear of their responsibility to check their emails and meeting minutes to review discussions and new working practices.
Is the service effective?

Evidence-based care and treatment

During this inspection care and treatment was delivered in line with legislation, standards and evidence based guidance. Managers checked to make sure staff followed guidance.

The service worked to the IR(ME)R and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. This included all specialities within the diagnostics.

There was a named radiation protection advisor (RPA) whose role was to advise on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations.

At the time of the inspection the RPA was gradually handing over the completion of policies and procedures to each departments RPSs. Whilst the RPA would continue to advice on local rules and comment on new policy it was felt the RPSs would have the best specialist working knowledge of their department. This would allow the RPSs to produce quality evidence based policies and procedures.

Policies and procedures reviewed were stored on the trusts intranet, and reflected current national guidance. There was a system in place for ensuring policies were reviewed in line with guidance changes and prior to policy expiry. All policies were being reviewed to meet standardised working practices across all sites. We saw a reporting CT and MRI policy for the children’s department for example was updated and approved in 2017, due for review in 2019. Staff told us the information was easily accessible.

The trust’s medical physics teams provided scientific support, advice and guidance on IR(ME)R regulations concerning the use of imaging equipment and monitored the radiology equipment and staff radiation dosages. The main legal requirements enforced by the Health and Safety Executive (HSE) are the Ionising Radiations Regulations 1999 (IRR99). In line with IRR99, the diagnostics department appointed RPSs whose role was to ensure staff followed the trust standard operating procedures and adhered to the radiation protection procedures. IRR99 requires employers to keep exposure to ionising radiations as low as reasonably practicable.

The RPA was responsible for completing annual audits to ensure staff were working in line with best practice guidelines. The last RPA audit was completed March 2018 reviewed working practices regarding the use of radioactive substances. This audit reviewed all aspects of working with radioactive substances including; the handling, storage, staff training, risk assessments and use of associated equipment such as spill kits. This was a detailed review of working practices with two small areas of action which were allocated to an action owner to complete which would be followed up at the following audit. We reviewed three completed RPA audits from January, February and March 2018 which all identified best practice guidelines were being followed by staff.

There were policies to ensure patients were not discriminated against. Staff were aware of trust policies and gave examples of how they followed guidance when completing care and treatment. Staff told us they would escalate any concerns, and seek further guidance if necessary.

Nutrition and hydration

People had sufficient fluid available to them pre, during and post treatment to ensure their hydration needs were met.

Patients attending as outpatients were often in the department for a short time therefore were not
routinely provided with food. Cool water fountains, or where not present, jugs of water and clean glasses were available for patient use.

Patients were advised on whether they could eat or drink prior to their treatment in their appointment letters. In the children’s department it was clearly identified on the toilet door children undergoing an ultrasound would require a full bladder to make their treatment more effective. If children had to use the toilet there was water available at reception and parents and carers were encouraged to ensure children drank before their treatment.

Pain relief

Pain relief, if required was available for patients although not routinely required.

Pain relief was not routinely used in diagnostic imaging, with the exception of when patients were attending for invasive procedures. Staff provided patients with pain control specific to the investigation being undertaken. Staff told us some patients were advised when procedures may be uncomfortable, and time was taken to reassure the patients and keep them informed of the length of time remaining for procedures. Patients with a learning disability were offered a pre-appointment visit to the department (where possible) to ensure they were familiar with the environment.

Staff ensured patient comfort prior to completing simple diagnostics, such as ultrasound scans, and x-rays. We saw patients were assisted to reposition themselves if they reported they were uncomfortable, and reassured during procedures of the time required in the position.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust provided evidence they were participating in NHS benchmarking. Benchmarking is used as a means for identifying areas for improvement which may impact positively on patient outcomes. This information identified how the trust was situated in line with other trust performances. Areas for improvement such as average report turnaround times, waiting times for CT scans and reporting backlogs were areas the trust were already aware of and taking action to improve.

The service had a programme of audit for reporting radiographers which involved peer reviews of each other’s work to improve standards and education. Discrepancy meetings for reporting radiographers and radiologists included teaching sessions and reviews of unusual cases.

Staff told us the trust had recently completed a neonatal intensive care unit (NICU) audit which had reviewed collimation, (this is the restricting and confining of an x-ray beam to a given area), repeat investigations and exposure of treatment on babies. The auditing team were described by staff as being ‘brilliant’ and changes had been brought in as a result of this audit which included new investigation request forms. These forms had subsequently been reviewed and updated in response to audit findings. New more specific investigation request forms were available for staff use.

The trust had identified work was required on increasing their performance in this area. In March 2018 the trust completed an ‘Exception Report’, reviewing the trusts previous three monthly performance against Stroke Contract Service Standards. This identified the national target of
admission to scan for suspected stroke patients was 48%. The trust had achieved, and exceeded this target in January 2018 when 52.8% of patients were scanned within an hour. The trust had achieved compliance of 38% in December 2017 and 40.7% in March 2018. Contributing factors to this lack of compliance had been identified and actions were identified for review each month to ensure ongoing progression with compliance figures.

A senior member of staff was proud of the work undertaken by departments in conjunction with the stroke teams, which was having a positive impact on patient outcomes. They provided an example of a patient entering QAH through the ED and within 12 minutes of arrival they had been imaged via CT and provided with their thrombolysis drugs in the CT recovery area. This joint approach to stroke care was ongoing to provide the best possible outcome for patients suffering from a suspected stroke.

**Competent staff**

The service made sure staff were competent for their roles. Managers monitored competence through appraisals, sharing learning and providing support for development. Trust data showed appraisal rates were above/below the trust target for all staff groups working within diagnostic imaging services.

From April 2017 to March 2018, 88% of staff within diagnostics at the trust had received an appraisal which was higher than the trust target of 85%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff eligible</th>
<th>Number of staff completed</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>70</td>
<td>69</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>86</td>
<td>79</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>26</td>
<td>23</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>377</td>
<td>330</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>205</td>
<td>175</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>767</strong></td>
<td><strong>678</strong></td>
<td><strong>88%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>
All staff groups aside from support to doctors and nursing (67%) met the 85% target for appraisal completion. Medical & dental staff achieved a 99% completion rate.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

There was an established development plan for newly qualified radiographers. Staff completed competencies and worked towards gaining additional skills. We saw competencies were specific to the area worked, for example, staff working within nuclear medicine had specific competencies for working within the department. Staff were encouraged to undertake additional training to support them in their roles. This included undertaking training to allow them to offer support in other specific areas of imaging such as chest and abdominal work.

All staff administering radiation were appropriately trained to do so. Those staff were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R. Each area within the imaging department had lead radiographers. This was a senior practitioner who worked with the senior manager of the department to ensure delivery of recommended standards as recognised by the Society of Radiographers (SoR).

Staff completing extended roles following appropriate training and supervision. This included participating in research secondments, supported by the trust. Staff completed good practice training and disseminated their knowledge with their colleagues. This enabled radiographers to report on specific types of images and radiographer assistants to complete tasks such as cannulation preparation for contrasting media.

The trust provided evidence that registered radiographers had in-date health care professional registration (HCPC). This is in line with society of radiographers’ recommendation that radiology service managers ensure all staff are appropriately registered.

Where reporting was completed by an external provider, quality assurance was ensured by the clinical leads who worked closely with the provider to ensure the service provided was in line with national guidance. This process involved senior clinicians monitoring a sample of reported images and checking the accurateness of the reports.

Electronic training records were maintained to ensure staff completed their relevant training and refreshers as required. Staff told us the training matrix was easy to understand and was colour coded to ensure they could easily identify which training subject was due to expire. Staff told us they were encouraged to complete training before it expired and were provided time during their working day to achieve this.

**Multidisciplinary working**

Staff felt part of the trust and worked together as a team to benefit patients. Staff however, often felt diagnostic imaging were seen as an independent unit and were not always asked to participate in multidisciplinary meetings.

We saw doctors, radiographers, radiographers assistants, porters and administration staff worked collaboratively to assist with the patients experience in the departments. For example, porters were quick to respond when asked to escort patients back to the wards or the ED. Conversations between all staff were respectful despite busy working conditions in the ED in particular.

Staff told us they did not always feel they worked in an integrated way with other clinicians from other specialities. Staff told us they felt part of the trust but did not always feel they were involved with meetings and discussions with other clinical business units. Mortality and morbidity reviews for example did not have diagnostic imaging representation despite patients often passing
through their modality. Staff acknowledged it was not always necessary for their attendance but felt they would benefit for seeing how their work contributed to patients overall care and treatment plan.

There were multidisciplinary one-stop clinics, such as in the breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment.

Staff took action to minimise patients repeat exposure to radiation for investigative procedures. For example, staff identified Dr’s were submitting duplicate requests for CT scans of patients heads. The completion of these requests placed patients at risk of repeated and unnecessary radiation exposure. Staff identified this as a concern and shared this with the referrers. As a result prior to investigation patients were asked and steps taken to identify if they have been subject to previous scanning which may still be appropriate for use. This removed the risk of patients receiving repeated short term exposure.

Bookings for community diagnostic services such as those based at Petersfield Community Hospital were made centrally at the QAH. Staff told us this was to ensure requests were vetted prior to patient appointments being offered which minimised the risk of repeat exposure and ensured the correct x-rays for the required results were requested.

**Seven-day services**

*The trust ensured patients had access to services at times which suited their needs and offered seven days a week emergency access to service.*

The trust provided a 24 hour x-ray service for patients admitted to the ED or urgent inpatient cases. The service provided urgent CT and MRI scans, with staff trained in both specialities working out of hours. This enabled investigations to be completed in a timely manner. There was an on call radiographer who supported with more complex investigations if necessary.

The service made sure patients had access to the main diagnostic services seven days per week. Computerised tomography (CT) and Magnetic Resonance Imaging (MRI) was provided from 8am to 8pm for outpatient scans. There was a 24 hour service, seven days per week for inpatients and emergency requests. Radiologists covered this service until 5pm and after this time an on call radiologist was available.

X-ray services for outpatients was available Monday to Friday from 8.30am to 6pm. X-ray within the emergency department operated 24 hours, seven days a week staffed by three radiographers. These staff also covered mobile theatres and inpatient wards.

Ultrasound services for outpatients was provided Monday to Friday 8.30am to 5pm. There was a 24 hour services, seven days a week for inpatients and emergency requests.

Nuclear medicine provided a Monday to Friday, 8.30am to 4.30pm service. The trust identified this sufficient to meet the demands of the service.

Fluoroscopy and interventional services for outpatients was available Monday to Friday from 8.30am to 6pm with an interventional radiographer on call 24 hours a day seven hours a week for emergency requests.

Breast symptomatic mammography services were provided Monday to Friday from 8.30am to 5pm. The catheterisation laboratory services for outpatients were provided Monday to Saturday from 8.30am to 5pm with Percutaneous Coronary Intervention available 24 hours a day seven days a week.
Health Promotion

Patients were supported with access to literature and advice to support health and wellbeing needs.

Staff encouraged patients to monitor their health. Within the main reception to the QAH was a wellbeing area which contained a number of health related literature staff could direct patients to view. For example we saw advice leaflets on the following:

- Obesity
- Quitting smoking
- Eating a healthy diet

These provided leaflets for patients to take with them which provided guidance and contact details of where patients could seek assistance to help them maximise their health and wellbeing.

In the CT, MRI and bone density department there was health guidance provided to patients on how the units of alcohol found in each drink and the levels how much a patient could consume before reaching risk levels. Additional advice was provided for patients on how to look after their bone health including taking calcium, vitamin D, exercise and a diet chart identifying healthy nutritional food balances.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, training compliance did not always meet the trust’s target.

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty training.

A breakdown of compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) courses from April 2017 to January 2018 for medical and dental staff in diagnostics is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>46</td>
<td>46</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>46</td>
<td>46</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>38</td>
<td>44</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff met the training target for all DoLS and MCA modules achieving 100% compliance in DoLS Intro and Mental Capacity Act Level 1.

A breakdown of compliance for MCA and DoLS courses from April 2017 to January 2018 for
nursing staff in the service is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS Intro</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff didn’t meet the training target for any of the MCA or DoLS modules. *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Not all nursing staff had received current training in DoLS and the MCA. Staff we spoke with however, were clear with their understanding and responsibility under the MCA identifying when a patient would be deprived of their liberty.

During the inspection we observed verbal consent was taken for all procedures, staff sought patient’s permission prior to initiating treatment. Consent was then documented on the patients electronic care record. Discussions included a description of the investigation, the possible side effects and the recovery period. Patients were given the opportunity to discuss and concerns or queries prior to confirming consent.

Staff told us the training they received focused on obtaining consent from adults prior to completing investigative work. When children presented for investigation, consent for treatment was sought from their parent, guardian or other appropriate adult over the age of 18 years.

For patients with a learning disability advice was provided for staff which identified ‘If a patient does not, in your opinion, have capacity to agree to or refuse treatment you are legally obligated to act in their overall best interest’. Staff were provided with consent forms which required completion following discussion with people who knew the patient best. This was required before staff were able to make their final decision to continue with the investigative procedure in a person’s best interest. The trust had a learning disability team who were available to offer advice and guidance on staff on how to seek consent in these circumstances.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Observations and feedback from patients confirmed staff treated them well and with kindness.

We observed staff caring for patients with compassion and understanding. Staff demonstrated a good understanding of patient’s anxieties and approached them with a calm and reassuring manner. All staff introduced themselves to patients, gave details of their name and checked they had attended the department for the specific investigation they had expected.

Patients were treated with dignity and respect and as individuals. During the inspection a young teenager (patient) arrived for an appointment; the radiographer spoke directly to them before they spoke to the parent who was accompanying them. This process meant the patient was included in their care from the moment they entered the department. The patient chose to have their x-ray without their parent present and this was respected by staff. The members of staff spoke to the patient following their x-ray and advised them where their images were going to be sent for review. This information was then relayed to the patient’s parent following this conversation.

Staff said they took the time wherever possible to interact with patients and their relatives. We observed staff taking time to speak with patients in a respectful and considerate way.

Patients we spoke with felt they were treated with courtesy when receiving care. A patient told us staff had “Really taken care of me, it’s lovely”, another patient said, “I think everybody has been really, really nice”. Two relatives both told us, “Staff have been lovely”. Written positive feedback was received from patients following their investigations within all the modalities, one patient had written to the radiology day case unit, ‘Very good experience, all staff welcoming and efficient, plenty of information at all stages of the procedures, thank you – allayed my anxieties early’. Another person wrote, ‘Everyone has been so kind and friendly, a very calm and caring atmosphere’.

Limited information was available to patients regarding their ability to request a chaperone if wished. Two posters were available in the x-ray and scanning department at Queen Alexandra Hospital however, these were not immediately obvious to patients. This information informed patients of their ability to request support during their appointment if required. We did however see staff enquiry with patients if they had any family of friends with them they wanted present during their treatment. In the X-ray department situated in the ED we observed a female being treated by two male radiographers whilst two female radiographers were working at the same time were attending to a male patient. Whilst staff were respectful of the female patient’s need for privacy and dignity during investigation the inspection team felt it more appropriate they were supported by female members of staff. When a further female patient entered the department male staff recognised they required support during preparation for treatment. As a result they sought a female member of staff who was present to offer support and assist in maintaining their dignity during their investigation.

Emotional support

Staff provided emotional support to patients to minimise their distress. Staff showed awareness of the emotional impact a patient’s care, treatment or condition would have on their well-being.
During the inspection we observed staff speaking with people in a way to comfort them and reassure them before their treatment. We observed staff speaking reassuringly with adult and child patients ensuring they were aware of what investigation they were to receive, why and what the outcome of this would be.

Staff told us they would often use distraction techniques when working with children who could become distressed at the unfamiliar and sometimes noisy environments. Starlight distraction boxes are portable toolkits filled with a variety of toys, games and puzzles providing staff with different ways of distracting a child whilst medical procedures are undertaken. At QAH staff also had access to play therapists to support children during treatment which minimised the distress the patient could experience.

Emotional support was not only offered by staff to patients in their department. One member of staff provided an example where they offered emotional support to a patient living with dementia outside of the hospital. Despite finishing work the staff member stayed with the patient managing their emotional distress whilst supporting their family members to ensure they were kept safe and was able to be taken home.

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

**Staff involved patients and those close to them in decisions about their care and treatment.**

We saw staff continually interact with patients before, during and after their appointments to ensure they understood the investigation they were due to receive. When patients were unable to communicate clearly staff told us they had a range of communication aides to support patient interaction including pictorial aids and translation services.

Patients told us they were involved with decisions about their care and treatment. One patient was being supported through a number of different treatments to discover what was causing their symptoms. They said they felt supported and involved during the process. When asked if they had been kept in the dark about any treatment options they told us, “No, not at all”. Another patient confirmed they were involved in their treatment planning telling us, “I know what they’re doing” before confirming their investigation plan which had been discussed with them.

Within the X-ray and scanning departments, we saw a sign which informed patients their results would be available from their referring doctor. Staff informed patients how long it would be before they received the results of their treatment and advised patients when it would be appropriate to book a repeat appointment with their GP to review the results.

**Is the service responsive?**

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

The trust planned and provided services in a way which met the needs of local people. The department offered a variety of services over four hospital sites which enabled patients to access investigations at their chosen hospital where possible.

The environment for patients waiting within the differing departments was adapted to meet patient needs. The children’s x-ray and ultrasound environment was an appropriately decorated waiting and treatment area. Children’s shows were playing on a TV and children’s games and books were available to keep patients occupied whilst awaiting their treatment.

In the main X-ray and scanning reception there was clear colour coordinated signage to support patients to find the right waiting area dependent on the type of investigation they were to
undertake. There were a number of sub waiting areas for patients which took them away from the busy waiting rooms to smaller quieter areas. This allowed patients wearing hospital gowns awaiting their treatment to sit in a more private area and for more privately held conversations. For patient comfort public toilets including those for disabled access were available in all main waiting areas. Access to drinking water was also available in all main waiting areas with reading literature and notice boards with hospital and health information available for patients to review whilst waiting.

The trust however, did not support patients living with dementia or sensory loss to negotiate their way through the hospital and between imaging departments independently. Upon entering the hospital signs directed patients to the correct departments however there were no large print or braille notices available to support patients. The corridors were wide to allow for the easy movement of disabled patients and where they were not naturally lit were well illuminated with good lighting. Handrails to support patients with their mobility were available but not painted in a contrasting colour to the walls to make them more obvious. This meant patients living with dementia and or eye sight deterioration would not have been able to differentiate between the wall and handrails to be able to use them to move independently.

There were no pictorial signs on the toilets and communal areas which would allow patients to quickly identify a rooms purpose. There were different coloured door frames surrounding treatment rooms but these were only marginally darker to the beige coloured walls and didn’t make it immediately obvious there was a difference between the walls and doors which patients would require. Staff however, did support people in finding their correct destination and all staff within the hospital supported visitors and patients with finding the department and rooms they needed.

The superintendent within the nuclear medicines department had identified the need to provide patients with additional support whilst moving around the hospital. As a result they had produced simple to follow instructions to allow patients to negotiate to different areas including the restaurant. These were simple, clear and easy to follow guidance for patients to ease their ability to move around the hospital.

Sufficient car parking facilities were available for patients whilst visiting the hospital for their treatment. A multi-storey car parking area adjacent to the entrance to the hospital offered a ‘pay on foot’ service. This allowed for patients to pay upon their departure, using both cards and cash, which minimised patient anxiety if their treatment were delayed. A further pay and display car park was available at the north of the hospital site. Patients with a disabled badge paid a nominal fee which allowed them to park all day in bays immediately adjacent to the hospital’s main reception.

Patients were able to choose the location of their investigation. We saw although patients were offered the next most appropriate appointment, they were able to change the location of the appointment to suit their needs. Staff told us when this happened, patients were informed of any change to the time scale and the length of wait for the investigation.

**Meeting people’s individual needs**

The service took steps to take into consideration patient’s individual needs to ensure care and investigations could take place which met these. However, these steps were not always consistent and information was not always passed between teams to ensure these needs could be met.
Staff told us despite good documentation they were not always aware if a patient attending from the ED had mental health needs or other additional needs such as a learning disability. Staff told us they would rely on a verbal handover and would check CRIS before each patients arrival to see if there were any particular needs they needed to beware of before offering investigations. If this information was not known or documented however, staff knew the appropriate action to manage patient’s needs. Staff explained should a patient become anxious or restless during a procedure they would use distraction and de-escalation techniques to calm patients especially those living with dementia.

Information regarding a language translation service was not always clearly publicised to patients however, staff said they were able to utilise staff within the hospital if patients required translation services. In the event appropriate staff were not available to assist staff had access to a telephone service which offered translation services.

Information asking female patients to make clear if they were potentially pregnant to staff had been published in 15 different languages to ensure this information was accessible and understood by all.

For other patients with additional communication needs, staff had access to pictorial aides to support patient understanding of the investigation they would to undertake. In the children’s ultrasound waiting area a poster clearly displayed in simple language what would happen during their appointment. This was accompanied by pictorial signs which showed the process children would experience during their treatment. Makaton and sign language symbols were also available for staff to aide communication. To support patients unable to stand or those with dementia associated eye sight loss we saw staff lower themselves to their knees so they were eye level with patients to aid their communication.

Staff recorded in notes when patients displayed behaviours staff might find challenging, to ensure other staff would be aware of these additional needs for future appointments. We saw this documented in a patient’s records when staff had attempted to obtain x-ray images however were unable to do so due to the patient’s demeanour. Staff moved the patient back to their bed and revisited the x-rays some time later when the patient was no longer agitated so treatment could be provided.

When patients attended the department for a planned appointment, for example as an inpatient or outpatient, staff were able to take additional steps to support patients with additional needs, such as those with dementia or a learning disability. Patients with a learning disability or those on the autistic spectrum who could find the procedures daunting were offered additional pre appointment visits. During these visits patients were offered the opportunity to become familiar with staff and equipment which would be used for their investigation. This meant more effective images could be taken as patients knew the sights and sounds to expect.

Most waiting areas were generally large enough to accommodate wheelchairs. We saw staff supporting patients with mobility aids to walk to the appropriate modality area. For example, we saw one member of staff supporting a patient who used a walking stick to walk to the appropriate waiting area. There were patient toilets located in most waiting areas, and all were suitable for the use of patients who had reduced mobility and required mobility aids or wheelchairs. Moving and handling equipment to allow for the movement and investigation of patients weighing 127 kilograms or 20 stone were available. This included access to specialist wheelchairs, seating and tables to support patients to access treatment.
Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and reporting on investigations were, on average, better than the England average.

From January 2017 to December 2017 the percentage of patients who waited over 6 weeks for diagnostic tests was similar to or better than the England average from December 2016 to November 2017 aside from July 2017 where performance increased to around 8% (England average in July 2017 was around 2%).

A senior member of staff confirmed the trust had a number of key performance indicators (KPIs) they were expected to reach regarding patient care. These included, exams reported within an identified timescale, from referral to first image being obtained,

- Cancer exams reported within 5 working days
- Urgent exams reported within 10 working days
- Routine exams reported within 15 working days

Following a previous inspection in July 2017 the trust was asked to provide weekly data to the Care Quality Commission identifying it was monitoring its KPIs and meeting patient needs. Data received for the week ending 22 April 2018 identified the trust was meeting urgent cancer waiting times for investigation. For routine requests 0.08% of all patients had not received their x-ray results within 15 working days. The proportion of urgent patients who had breached the trust's KPI for a CT report had reached 75%. This had been identified as being due to a less than expected outsourcing capability.

The trust had identified they were not always achieving internal KPIs in relation to reporting and had taken action to try and address this. This included dedicating two members of staff for Urology and gynaecology sub speciality CT and MRI reporting, two sonographers undertaking extended training for Gastro-intestinal Ultrasound and extending the Ultrasound workforce with training for obstetricians and midwives. The trust had secured two means of outsourcing for additional CT and MRI reporting capacity. The outsourcing companies had a 72 hour KPI which was used to ensure internal KPIs were achieved.

The trust's central booking team managed the appointment systems which meant they could
manage team workloads appropriately across all sites allocating appointments according to the availability of the service. This enabled timely access to investigations and ensured services were utilised effectively to manage patient waiting times. Patients were given a choice as to which hospital they wished to attend. Patients confirmed they had been given a choice of hospital and booked an appointment which was convenient to them. Patients were informed if there any delays and or any harm which may be associated with waiting for an appointment at their chosen site, to enable an informed decision to be made.

GP referrals for investigations were screened as per vetting process for all requests. When GPs required a “plain film”, patients were able to book an appointment at any X-ray department. The GP referral was sent electronically, which meant a patient could attend any X-ray department and confirm their identity to complete the request. Plain film refers to an X-ray taken without the use of a contrast medium.

Patients we spoke with were pleased with the timeliness of their appointments and when it had been possible patients had their appointment times brought forward reducing their anticipated waiting time for investigation. A patient told us during their treatment it had been identified they no longer needed to be treated on the cancer pathway. This is a pathway which automatically reduces waiting times for investigation. Despite no longer fitting within this pathway the patient told us, “Nothing has slowed down and they’re doing everything, all the tests again six weeks later”, and, “waiting times and communication is excellent”. Another patient told us, “It’s all been so quick, it (treatment) was planned for a week later after seeing the consultant”. Patients were able to access timely appointments and investigations.

In the event of concerns regarding a patient’s image processes were in place to ensure patients received the most timely and appropriate care to meet their needs. Upon review of an initial x-ray for example if staff were unsure whether or not a patient required immediate care they could seek support from reporting radiographers based at QAH. The image would be reviewed remotely and immediate advice provided as to whether or not the patient could wait to be seen by their GP or would require emergency care.

Learning from complaints and concerns

The investigation of complaints did not take place in a timely way leading to delays in responding to the complainant. The service did not complete investigation of, respond to, and close complaints within agreed timescales

From January 2017 to December 2017, there were 24 complaints about diagnostics. The main themes were clinical treatment, test results and attitude and behaviour of staff. The trust took an average of 36 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 working days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Patients were offered access to complaints information in all waiting areas by trust posters. These posters identified how patients could raise a complaint which included speaking with staff, writing to the chief executive of the trust or emailing a provided complaints email account.

Patients unable to provide their complaint in writing were given information on how to complain via the Patient Advice and Liaison Service (PALS). PALS would then assist patients to make their complaint and support them through the process. Patients were also provided guidance on how to complaint to Healthwatch Portsmouth, an advocacy service or the independent health service
ombudsman. We also saw feedback boxes in main reception areas with ‘Comments, Complaints and Concerns’ leaflets alongside to allow patients to share their experiences of treatment received.

We asked the trust to provide us with evidence of recently investigated complaints so we could assess the quality of the complaints process. We reviewed three complaints none of which had been responded to in line with the trust’s identified timescales. We asked for documented actions and lessons learned as a result of these complaints to prevent reoccurrence however, this was not provided.

We reviewed the trust’s annual complaints report for the year April 2016 to March 2017 which had been produced in September 2017. This identified changes and improvements had been made as a result of the complaints received by the diagnostic imaging services during this time frame.

Patients raised complaints identifying they were unhappy about the delay in receiving results from x-ray and CT scan. As a result the trust had created reporting lists to try and clear the outstanding reports which were required to meet patients needs. We saw this work had been completed prior to our inspection. The trust had also recruited an additional assistant to support the consultant in managing the results from x-ray and CT scans to minimise the time patients waited to receive a response. We saw the trust responded positively to themes identified by patients as areas of concern.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff felt supported and valued in their role by their managers and had access to their executive board.

During this inspection, we saw the diagnostic services had an established management team, which was focused, enthusiastic and driven to make improvements to the services provided. All staff reported leadership within the diagnostic imaging department was strong, with visible and approachable managers. Staff told us leaders had the skills and experience to appreciate the role they completed and offered valuable support.

Staff said the imaging service manager and superintendent radiographer were visible, interested in their wellbeing and always available to provide advice where required. One member of staff told us, “(I) feel like I’m well supported there’s a good management system so you’ve always got someone you can go to and if you don’t want to come to someone here you can go to others out of the department, there are always others you can go to” which was echoed by most other staff we spoke with.

The diagnostic imaging directorate was part of the Clinical Support Clinical Service Centre and provided a county wide service. The directorate was led by a, clinical director (consultant radiologist) and an imaging services manager. There was a clear management structure in place with lines of accountability.

We spoke with senior members within the directorate and found they were all aware of the plans for the service and shared the aspirations of the trust. The team appeared focused and driven to improve the quality of the service provided to patients.
Staff were aware of the senior executive team, however, not all felt they were immediately visible, particularly staff in community locations. Staff felt communication from the chief executive was good however, as they produced weekly emails to all staff which made them feel they had ‘strong links’ with the trust even when working in community locations.

It was acknowledged by senior staff the recruitment of radiologists and radiographers was a national concern with a shortage of persons choosing the career option. As a result the trust had proactive succession planning and staff development processes in place. Staff were encouraged to participate in additional training to increase their range of skills and allow them to progress their role. Staff repeatedly told us the trust liked to “grow their own staff”. The trust were taking positive steps to recruit staff. This included recruiting staff a band lower than originally required offering training and career progression to improve their skills and knowledge base. Staff told us they appreciated being able to enhance their professional knowledge. One member of staff told us, “I think it’s good particularly within our department, a lot of scope for development and career progression which has been really positive”.

**Vision and strategy**

**Staff said they were involved in developing the services visions and values. Staff said the trust’s vision was focusing on the quality of care and treating patients with respect and dignity.**

Senior staff told us they were in the process of conversations with their clinical director to work towards creating a shared vision for the service. This information was being shared with senior staff and their feedback sought to ensure it met the needs of the trust, the service and patients. At the time of the inspection this was not yet in a finalised format.

Staff told us and we saw they were asked to comment on what safe, effective, caring, responsive and well led care looked like to them as an individual within the organisation. These headings were written on staff notice boards throughout the trust and staff were being asked to write what that title meant to them. A member of staff told us this information was then being collated and pulled together in order to create the service’s visions. Staff told us they felt very involved in this process.

The trust’s overarching vision for the delivery of care had been published in November 2016 and remained unchanged at the time of the inspection. These values centred on the main principle of patients receiving the ‘Best Care’, from the ‘Best People’ at the ‘Best Hospital’. In order to achieve this aim staff were asked the following:

- To put the quality of patient care above everything
- To provide patients the respect and dignity they would want for a loved one
- To work together in order to achieve the best outcome for patients
- To strive for efficiency through continuous improvement

Staff were able to discuss the trust’s visions and demonstrated they placed these at the heart of their daily activities and interactions with patients. One member of staff told us their responsibility was, “Providing care in line with trust values, respect and dignity, working together through CT or MRI and providing a safe and efficient service to make sure the people who come to us have a positive experience”. Another member of staff told us the visions centred on, “The quality of care and providing this with respect and dignity”.

Staff said the trust visions and values were included within their appraisals and they would have to demonstrate they were meeting these values and provide evidence to support this. This
process reinforced staff awareness of the trust’s visions for the service and were also used as a measuring tool for staff performance.

A senior member of staff told us the recruitment of the new Chief Executive in 2017 and changes in board members had been a positive change for the trust. This member of staff said, “I’m very, very optimistic about the new board. The appointments at board level have been excellent. I really think there’s a positive outlook, a lot of hard work going into change such as the cultural change programme”. At the time of the inspection, the trust board were creating a new service strategy which would accurately reflect where the trust was heading and developments already achieved.

The imaging services manager told us their aim was to ensure the service was working towards being included in the Imaging Services Accreditation Scheme (ISAS). This is an accreditation scheme assessed by the United Kingdom Accreditation Service (UKAS) on behalf of the Royal College of Radiologists and College of Radiographers. This programme is designed to help diagnostic imaging services ensure they provide consistently high quality services by competent staff working in safe environments. The service had previously presented a business case but had been unsuccessful however; it was still the aim of the service to achieve this accreditation although the timescale for doing so was not known.

**Culture**

Throughout the inspection, staff told us they were happy with their work and enjoyed working for the trust. All the staff we spoke with said positive patient experiences drove their enthusiasm for their role. Staff felt listened to and said they worked well as a team. There was a positive culture for delivering high-quality care.

Staff told us they had monthly team meetings and would participate in these fully. We saw these were well attended, with minutes available to all staff.

Senior staff told us the culture of the service revolved around providing individualised treatment to patients and responding to them as if they were members of their own family. This was part of the trust’s visions for the quality of service provided but staff repeatedly reflected this was the overall culture of staff working within the service. A member of staff told us, the culture is to treat patients “As if they’re your own family, treat patients as an individual, it puts a different slant on things. That’s how he (the clinical director) wants us to reflect, pretend it's your mum or child in Accident and Emergency and that is the culture, we're a very caring hospital”.

All staff spoke proudly about their work in their individual modality and also as a part of the diagnostic imaging service. Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which were encouraged by senior staff. Staff told us they felt valued and were supported by colleagues and senior managers. Staff felt they could approach the chief executive or the freedom to speak up guardian who they felt was “Very approachable” if they had any concerns. One member of staff told us, “All grades are approachable” and another said, “I like it (here), our team is really supportive and it makes it a pleasant place to work”. A senior member of staff told us, “I’m really proud of our department, such a good team”.

Staff spoke positively about working for the trust and felt their wellbeing needs were acknowledged by senior staff. Staff also took part in group charity events to raise money for the trust which enabled them to interact with their colleagues outside of the work environment to build relationships and offer individual support. Well-being services were offered to staff included
access to services including counselling, fit for work programmes, onsite gyms, a mediation and chaplaincy services.

Staff told us the trust positively praised staff when they had completed work which had gone ‘over and above’ for patients. The trust had a number of ways to recognise and reward staff for their positive action towards meeting patient needs. This included informal ‘thank you’ visits from senior staff, local certificate ceremonies or more formal processes such as award ceremonies. The Chief of Service produced a monthly ‘shout out’ email which was circulated to the trust and contained names of staff who had come to notice for the positive work completed. The trust held annual awards where all staff could nominate colleagues who they felt deserved recognition for the role they performed.

Staff commented throughout the inspection their enthusiasm for working for the trust and for the diagnostic imaging service telling us, “I love working here”, “Good bunch of people”, “Really lucky”, “I can’t fault them (the trust)”, “Nice department, nice staff”.

Some staff said they could access the executive team to escalate concerns if required and there was effective communication from the chief executive. We were told the new executive had held drop in events across the sites to introduce themselves to staff which had appreciated.

Staff were aware of the duty of candour (DoC) regulation and evidenced through discussion the appropriate application of the duty when required. The DoC is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

The trust had a ‘Duty of candour and being open policy’ which was in date and provided guidance to staff, and patients, the processes which would lead to the duty being complied with. Discussions with staff evidenced the correct processes were followed when a patient had been caused moderate or severe harm or died as a result of a serious incident. We saw evidence of written duty of candour being complied with as part of a serious incident review.

**Governance**

The service used a systematic approach to continually improving the quality of its services whilst maintaining standards of care. A governance structure was in place which was effective and promoted staff confidence.

At this inspection we saw structures, processes and systems of accountability to support the delivery of high quality care. Regular quality assurance meetings were held across the modalities to ensure risks, where identified, were discussed, raised for action where required and subsequent learning shared with staff.

The service held a number of regular meetings where quality, service performance and risk were discussed. These included and were not limited to;

- **Fortnightly – Incident review meetings** - all reported incidents were discussed and if identified as requiring additional actions these were delegated to the appropriate member of staff. The superintendent for the modality would maintain an overview of the incident to ensure all appropriate action taken before closing the record. Learning identified from these meetings was shared with staff something they confirmed occurred.
- **Fortnightly - Clinical Advisory Group** – this was a teleconference held every two weeks which included internal and external chest radiologists. This had been used to discuss the
processes around minimising the risk of a backlog of images accumulating in future. All staff in this group were involved in reviewing the draft report regarding the backlog situation and would be supervising the new reporting policy for chest x-rays for QAH.

- Monthly – Cases to learn from meetings (also known as discrepancy meetings) held to identify whether or not errors had been made in the reporting of images. It was seen as an improvement tool and had been positive in sharing staff learning. Senior staff members told us they found these a useful process to reassess their skills and reflect on judgements made. Any member of staff was able to place a case on the list for discussion at these meetings making it an open and transparent process.

- Quarterly – Radiation protection and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) group meetings chaired by the RPA. These were attended by the imaging service manager and radiology team leaders. These were used to discuss serious incidents, audits which required action and updates on policies.

Other meetings held included operational radiation protection groups, monthly staff meetings and medical radiation committees.

The service had recently commenced a CT Optimisation Group, chaired by a radiologist, and including senior staff and the medical physics team. Staff spoke positively about the work of the group including an audit requested by the team which had resulted in a change of working practice. This had commenced following an audit reviewing the use of head holders in paediatric scanning devices. It was found the head holders could potentially expose a child to a higher dosage of radiation and as a result immediate action was taken. The head holders were removed and staff informed of the change of working practice. This action was taken in order to keep vulnerable patients safe minimising the risk of repeated or prolonged exposure to radiation doses.

The trust used a number of different auditing systems and process to ensure the quality of the treatment delivered remained of a high standard. Staff from all modalities at all seniority levels were involved in auditing processes, equipment and procedures with actions taken to improve where shortfalls identified. One member of staff had requested to undertake an audit on the number of images being rejected pre-reading stage. During this process they identified the need for staff to provide more detailed feedback on what was being rejected and the reasons as to why. In February 2018 they identified a number of rejections in relation to the obtaining of lateral imagery. The staff member identified the reason for repeated rejections and circulated information to all staff to enable them to learn how to improve the quality of the work completed. At the time of the inspection they had not been able to identify if this had resulted in an immediate impact in the number of rejections received.

Staff told us the Dose Optimisation Team had recently completed an audit relating to the positioning of patients during a CT scan. This had been undertaken to identify if working practices could be amended to reduce the dose of exposure a patient received during treatment. Staff told us they had found this a useful process which had resulted in having a positive impact on patients during treatment as they were exposed for the minimal time possible.

In 2008 the World Health Organisation (WHO) introduced a surgical safety checklist applicable to all surgical teams to be used for every patient undergoing a surgical procedure. The trust’s services auditing lead audited patient identification checks completed prior to fluoroscopy investigations in line with the WHO guidance. The last audit had been completed in March 2018 with no concerns identified.
Management of risk, issues and performance

The trust took action to proactively identify risks to the service which could impact on the quality for the care required. All staff took responsibility to ensure risks were minimised wherever possible without compromising care quality.

All staff identified risks for the trust wide service which were reviewed regularly by senior staff, this was evidenced in the services risk register. The risk register included 43 diagnostic specific risks which were provided an initial scoring indicating their level of risk.

Risks were categorised as high, moderate or low risk and scored accordingly. 12 risks were rated as low risk, 19 risks rated as moderate, and 12 risks were rated as high. The risk score was one to 20, with 20 being the most severe.

The high risks (scored 15-20) included:

- Staffing levels within CT and MRI
- Equipment requiring replacement
- Recruitment difficulties
- Insufficient in-patient CT capacity to meet demand.

Moderate risks, scored nine to 12, included areas such as equipment replacement and difficulties recruiting specialist staff. Low risk areas included the risk of potential failure of equipment and not having a single sex inpatient ward. Risks were reviewed regularly and updated when any actions were taken to mitigate risk or harm.

Where risks were identified the service took steps to identify how the risk originated, completed analysis to identify why the risks existed then took steps to minimise these risks.

The trust identified a risk regarding patients not attending their colonoscopy appointments. This created both a concern regarding patients’ health and wellbeing as well as the costs associated with patients not attending their appointments. Senior staff identified the need for a root cause analysis to be completed in order to identify the reasons for these repeated failures to attend.

During this work a number of reasons were identified for patients not arriving or receiving treatment which centred on pre-treatment processes and lack of patient information. As a result a trial pre-assessment clinic was set up to inform patients of the reasons for their treatment, the pre-treatment processes to be followed by the patients and the benefits for doing so. Following this trial analysis identified same day cancellations dropped as a result. Feedback was received from patients who were pleased with this clinic as it meant they were able to choose their appointment. Work was ongoing at the time of the inspection to present a business case to make the pre-assessment clinic an ongoing one.

This work was being repeated within the radiography department at Gosport War Memorial Hospital. At the time of the inspection they were undertaking analysis of the number and reasons behind did not attend (DNA) patient appointments. The aim was to identify whether or not a clear reason could be identified for non-attendance which would allow proactive work to be completed to minimise these and enhance patients health and wellbeing.

Managing information

The service collected, analysed, managed and used information well to support all its activities.
The service regularly reviewed quality performance which was discussed at meetings across all modalities. This information was shared electronically with staff through minuted meeting minutes to ensure their awareness of where improvements in performance could be made.

Minuted staff meetings were seen for a number of groups across the service including:

- Nuclear Medicine IR(ME)R and Radiation Protection Group
- Nuclear Medicine Staff meeting
- Band two staff meetings
- Radiology IR(ME)R and Radiation protection speciality group minutes
- Band 7 meeting minutes
- Diagnostic imaging service intentional meeting
- Radiology nurse meeting
- Admin staff meeting
- CT/MRI staff meetings

Records showed information relating to service finances, compliments, complaints and figures relating to reject analysis were discussed at all levels across all modalities. These discussions included how to meet increasing patient demand when identified which involved the use of mobile CT and MRI scanners. These were used through the winter period in response to the increasing patient demand. These meetings also reviewed adverse incidents, how to relieve increasing pressure on capacity by seeking guidance regarding the use of alternative imaging techniques and panels being set up for non-medical referrers to reduce the number of inappropriate referrals being made for investigations. Discussions were inclusive of all staff at all levels and information shared to ensure improvements were made.

Message of the week (MOTW) were also used to share the findings of reject analysis in order to improve performance. These were circulated to all modality staff. These included information on figures relating to the rejection of images and identified common themes to prevent reoccurrence.

Following our previous inspection in July 2017 the trust was required to provide weekly monitoring reports to the Care Quality Commission. These included data in relation to a number of identified key areas including (but not exclusive to):

- the total number of urgent patients who had attended for an MRI but the results had not yet been reported
- the number of routine patients waiting more than the trusts KPI of 15 working days for an MRI report
- the number of plain film requests made and the number of urgent patients who had breached the trusts KPI of 10 working days

The trust reviewed and shared this information weekly using it as a tool to document if KPIs had not been met and provided justification for this. For example, the longest waiting time for a reported radiology plain film request performed after 20 September 17 was reported on 22 April 2018 to be 171 days. The trust was able to justify why there had been an extensive wait for this plain film to be reported. This was being used as a tool to monitor, review and assess overall performance of the trust against national and trust set KPIs.

**Engagement**

The service engaged with patients seeking feedback to improve the quality of the services provided. Staff told us the trust sought their feedback involving them in the direction of the service and the completion of staff surveys.
Senior staff told us the service received limited feedback from patients despite actively participating in friends and family test surveys. To increase the level of feedback received from patients we saw comment boxes in every modality reception with comments and concerns cards readily available.

The trust regularly collated this feedback and saw this as an opportunity to improve the quality of the service required. Patient feedback and actions taken as a response was not observed throughout the modalities however we saw action was taken to address any negative feedback if received. Patient feedback was viewed for the radiology day case unit for March 2018. During this time 43 responses were received of which an average 4.88 positive score out of 5 was received with 100% of patients likely to recommend the unit for treatment. Positive comments were received including, ‘Staff were polite and informative, radiologist professional and thorough’, ‘Excellent care, made to feel relaxed, everyone very kind and attentive’, ‘the care and staff were outstanding, (staff member) was very kind and helpful’ and ‘all the care I have ever received from QA has been exemplary, this unit is no different. All staff are courteous, respectful and professional, additionally all information received prior to the visit was clear, useful and extensive’.

An audit was completed on patient satisfaction of the use of the mobile CT scanner used between December 2017 and March 2018. Patients were asked to quantify their level of satisfaction on the use of the scanner following some previously raised concerns regarding radiation incidents. The areas covered during this audit included (and not limited to) staff professionalism, respect and dignity, concerns and communication, adequacy of waiting facilities and information given for example. 90% of patients responded positively to the treatment they had received. The audit identified areas where patients wished to see improvement, this included accessibility to the mobile scanner being inadequate to meet all patient’s needs. As a result the demographic of patients allocated to the mobile scanner was being reviewed to ensure the unit met patient needs and staff were reminded to encourage patients to use the lift to enter the mobile scanner to improve access. The audit was to be reviewed following these revisions to ensure patient satisfaction in all areas increased, this had not been completed by the time of this inspection.

The trust requested staff participate in an annual survey to share their views on how they felt the service and the trust was operating. Following these surveys the results were analysed to identify where key areas of improvement could be made for staff wellbeing.

The last staff survey for CT/MRI, for example, had been completed in 2017 and areas of improvement identified as a result of staff feedback. During this survey only 19% of staff agreed there were enough staff to enable them to complete their role fully. As a result a business case was prepared to increase the establishment for all staff. Staff told us additional staff were being recruited at the time of this inspection. Only 48% of staff agreed or strongly agreed their manager provided them feedback on their work. At this inspection most staff spoke positively about their appraisal system and 88% of staff had received a yearly appraisal.

Staff answered positively in questions about the role they were asked to perform, the interaction with their immediate line managers, their personal development opportunity and about the trust as an organisation to work for. The trust sought staff feedback regarding their role and positive action was taken when concerns were identified.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.
The trust sought ways to improve patients experience whilst providing a more cost effective service. In the scanning department the trust had purchased a contraster warmer machine to support them in their work. This machine automatically warmed medicine used for contrasting media CTs at the point it was injected into the patient. Warming this medicine decreases its viscosity and ensures it is more comfortable for patients when used. The use of this innovative equipment increased the medicines shelf life and made the experience a quicker and more comfortable process for patients.

The clinical leads within radiology confirmed they were continuously striving to implement changes and improvements for the benefit of the patients. When areas for improvement had been identified staff told us they felt the required changes had been implemented quickly. Staff told during meetings they discussed the previously issued S31 warning notice regarding the backlog of chest x-rays. Staff felt whilst initially disappointed this had occurred during discussion they identified the issuing of this notice as a positive course of action. Staff told us it had positively impacted on the quality of the service offered to patients. The outsourcing of images, training of existing staff and the recruitment of new staff allowed the service to offer a more timely and efficient service to patients.

Staff took personal responsibility to continuously improve their learning and use this to benefit colleagues and patients. Nuclear medicine encouraged staff to actively participate in creating SoR and being part of the nuclear medicine advisory group. One senior member of staff had recently applied to be an expert for the European Federation of Radiographer Societies (EFRS). The EFRS represents over 100.000 Radiographers and over 8,000 students through 38 national societies/professional bodies, 1 trade union and 59 institutions involved in radiography education all over the geographical region of Europe. The role of the EFRS is to represent, promote and develop the profession of radiography in Europe, within the whole range of medical imaging, nuclear medicine and radiotherapy and moreover everything that is directly or indirectly related or beneficial to this role, everything in the broadest meaning. Becoming an expert for the society would allow the member of staff to have access to knowledge which could positively impact on the work conducted by the trust.